

# Enhanced MEC Plan\_Plan 1

Benefits Enrollment Form  New Employee  Rehire Rehire Date \_\_\_\_\_

<b>Employee Information</b>	
Name (First and Last) <b>Jose Santiago</b>	Social Security Number <b>344 82 2699</b>
Address <b>32 S. Moline St</b>	City <b>Aurora</b>
State <b>CO</b>	Zip Code <b>80012</b>
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth <b>07/26/1988</b>
Date of Hire	
Phone Number: <b>720 229 8021</b>	Email Address: <b>santiago.joser100@gmail.com</b>
<b>Please Select Desired Coverage:</b>	
<input checked="" type="checkbox"/> Employee Only - \$24.00/Week	<input type="checkbox"/> Employee+Spouse - \$38.00/Week
<input type="checkbox"/> Employee+Child(ren) - \$36.00/Week	<input type="checkbox"/> Family - \$63.00/Week

<b>Dependent</b>				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
<b>Dependent</b>				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
<b>Dependent</b>				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

**Other coverage information including Medicare/Medicaid**

NAME OF PERSON COVERED (FIRST, LAST):

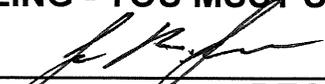
EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

**IF ENROLLING - YOU MUST SIGN HERE**

Employee Signature  Date **5-31-17**

EMPLOYEES DECLINING  I am DECLINING coverage

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

**IF DECLINING- YOU MUST SIGN HERE**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

# Fixed Indemnity Medical Benefits\_Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION \_\_\_\_\_ Rehire Date \_\_\_/\_\_\_/\_\_\_\_\_

## ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

### A. REQUIRED EMPLOYEE INFORMATION PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name Jose R Santiago Social Security # 344 822699 Home Phone 720 229 8021 Sex  M  F  
 Address 32 S. Moline St Apt. # N/A  
 City Aurora State CO Zip 80012 Date of Birth 7/26/1988

### B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_ Medicare Effective Date \_\_\_\_\_  
 Name of Covered Person (s):  
 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

### C. LIMITED BENEFITS PLAN SELECTION Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>
Employee Only <input checked="" type="checkbox"/>	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
<b>NO</b> to ALL Benefits <input type="checkbox"/>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>STD is not available to persons who work in CA, HI, NJ, NY, or RI.

**For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.**

Name Eric D. Santiago Relationship Brother

### D. REQUIRED DEPENDENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F Relationship  Spouse  Child  Domestic Partner  
 Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F Relationship  Spouse  Child  Domestic Partner  
 Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F Relationship  Spouse  Child  Domestic Partner  
 Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F Relationship  Spouse  Child  Domestic Partner

### E. REQUIRED SIGNATURE YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

DATE 05/31/2017 ▶ SIGNATURE