

ENROLLMENT FORM - PLAN 2

ESC UNAV P2 v15.1

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK
(Must Be Filled Out)

Social Security Number 073-52-4109
 Date of Birth 06/07/1962 Sex M F
 Name Leonard M. Jordan
 Street Address 600 N. Bruffey St.
 City Salem State VA Zip 24153
 Home Phone 540-353-0642

Do you or any dependents have Medicare?
 Yes No If Yes:
 Medicare Health Insurance Claim Number (HICN)

 Medicare Effective Date ____/____/____
 Names of Covered Person(s)
 1. _____
 2. _____
 3. _____

BENEFIT SELECTION Weekly Rates

SELECT COVERAGE LEVEL
 You MUST select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.
 Employee Only Employee + Family
 Employee + 1 NO to all indemnity benefits.

FIXED INDEMNITY MEDICAL 
 YES \$20.91 Employee Only
 \$42.44 Employee + 1
 NO \$56.67 Employee + Family
 This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL 
 YES \$6.17 Employee Only
 \$12.34 Employee + 1
 NO \$20.36 Employee + Family

TERM LIFE 
 YES \$0.60 Employee Only
 \$0.90 Employee + 1
 NO \$1.80 Employee + Family

SHORT-TERM DISABILITY 
 YES \$4.20 Employee Only
 NO
 Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

REQUIRED DEPENDENT INFORMATION

Name _____
 Social Security Number _____
 Date of Birth ____/____/____ Sex M F
 Relationship: Spouse Child Domestic Partner

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 Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.
 NAME OF BENEFICIARY Ragena L. Jordan
 RELATIONSHIP Spouse
 Accidental Death & Dismemberment is part of the Term Life Benefit.

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.
Signature Leonard M. Jordan Date 05/16/2016

New Employee
 Rehire *Rehire Date* _____

For Status Change Please Check: You **MUST** provide a supporting Document

Change of Status Birth/ Spouse Loss of Coverage Plan
 Adoption Change
 Marriage Cancel Employee/Dependents
 Divorce

Date of Status Change: _____

Benefits Enrollment Form

Employee Information			
Name (Last, First, MI) <i>Leonard Jordan, Leonard M</i>		Date of Birth <i>6/7/62</i>	Social Security Number <i>073-52-4109</i>
Address <i>600 N. Bruffey St.</i>		City <i>Salem</i>	State <i>VA</i>
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Phone Number: <i>540-353-0642</i>	Date of Hire <i>05/17/16</i>
Please Select Coverage Elected: Enhanced MEC Plan Coverage Level :		Email Address:	
<input type="checkbox"/> Single - \$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	

Dependent Information				
Dependent				
Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date
Social Security #				
			Coverage Elected <input type="checkbox"/> Medical	Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate
Dependent				
Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date
Social Security #				
			Coverage Elected <input type="checkbox"/> Medical	Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate
Dependent				
Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date
Social Security #				
			Coverage Elected <input type="checkbox"/> Medical	Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):	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 _____

EMPLOYEES DECLINING Declining due to other 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 *Leonard Jordan* Date *5/16/2016*