B1 **221900-CMG** OFFICE USE ONLY LOCATION _____ New Hire ☐ Rehire ☐ Date __/__/____

ENROLLMENT FORM

ESC/MEC ES P2DM v18.2

A. REQUIRED EMPLOYEE INFORMATION

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

Name	Home Phone	
Lindsay Granderson	812-228-6284	
Social Security #	**Date of Birth**	**Sex**
315-11-7092	1/10/92	M ☒
Address		**Apt. #**
12275 Claude Ct.		731
City	**Zip**	**State**
Northglenn	80241	CO

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?
☐ Yes ☒ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C.
Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection.
This plan is underwritten by BCS Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$23.69**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + 1	☒ **$48.08**	**$10.80**	**$4.92**	**$0.90**	
Employee + Family	☐ **$64.20**	**$17.82**	**$6.56**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No

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

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name Kyle W. Indorf Relationship Boy friend

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
Marley Granderson	284-41-6397	3/11/13	M ☒	☐ 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. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82219000-M-CMG **Direct Payment Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$62.00** Employee Only ☒ **$69.02** Employee + 1 ☐ **$73.67** Employee + Family ☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE 08/29/2017 ▶ **SIGNATURE**