employer solutions staffing group
Leveraging Resources in a Changing Market

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Benefit Plan Administrators, Inc.

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form ☒ New Employee_ ☐ Rehire Rehire Date_____

Employee Information

Name (First and Last)		Social Security Number	
Roxy Clare		522-94-2376	
Address	**City**	**State**	**Zip Code**
1016 E 111th Place	Northglenn	Co	80233
Gender ☐ Male ☒ Female	**Marital Status** ☐ Single ☒ Married ☐ Divorced	**Date of Birth** June 29, 1961	**Date of Hire** 5/18/2017
Phone Number: 303-548-4741		**Email Address:** mrjjclare@comcast.net	

Please Select Desired Coverage:

☐ Employee Only - $24.00/Week ☐ Employee+Spouse - $38.00/Week ☐ Employee+Child(ren) - $36.00/Week ☒ Family - $63.00/Week

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
Michael	J.	Clare	524-11-3933	6/3/61	☒ Male ☐ Female	☒ Spouse ☐ Child ☐ Domestic Partner
Jordan	A	Clare	523-87-3335	11/7/92	☒ Male ☐ Female	☐ Spouse ☒ Child ☐ Domestic Partner
Jason	A	Clare	524-97-1161	4/11/95	☒ Male ☐ Female	☐ Spouse ☒ Child ☐ 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 Roxy A Clare Date 5/18/17

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

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

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	Social Security #	Home Phone	Sex
Roxy A. Clare	522-94-2376	303-450-0221	M [X]

Address	Apt. #
1016 E 111th Place	

City	State	Zip	Date of Birth
Northglenn	Co.	80233	6/29/1961

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

[ ] Yes [X] 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 [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only [ ]	$20.25	$6.17	$2.42	$0.60	$4.20
Employee + 1 [ ]	$41.10	$12.34	$4.92	$0.90	
Employee + Family [ ]	$54.88	$20.36	$6.56	$1.80	
NO to ALL Benefits [X]	[ ] Yes [ ] No	[ ] 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 Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Sex M F	Relationship
				[ ] Spouse [ ] Child [ ] Domestic Partner
				[ ] Spouse [ ] Child [ ] Domestic Partner
				[ ] Spouse [ ] Child [ ] Domestic Partner
				[ ] 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 05/18/2017 ▶ **SIGNATURE** Roxy A. Clare

This is an Essential StaffCARE Enrollment Form.