

ENROLLMENT FORM

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK

(Must Be Filled Out)

Social Security Number 625-02-4125

Date of Birth 05/07/1973 Sex M F

Name Senaith Bobus

Street Address 1529 Blue Stem Ln

City Newport State RI Zip 05055

Home Phone 651-890-6532

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. _____

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY

RELATIONSHIP

Accidental Death & Dismemberment is part of the Term Life Benefit.

OPTION 1 FIXED INDEMNITY PLAN 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
- YES \$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
- YES \$12.34 Employee + 1
- NO \$20.36 Employee + Family

TERM LIFE

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

SHORT-TERM DISABILITY

- YES
- NO \$4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

OPTION 2 82193010-M-EMP MEC WELLNESS/PREVENTIVE PLAN Monthly Rates

- \$58.87 Employee Only
- \$87.73 Employee + 1
- \$186.99 Employee+ Family
- NO to MEC Wellness/Preventive Plan

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

Date ____/____/____