employer solutions staffing group llc
Leveraging Resources in a Changing Market

bpa
Benefit Plan Administrators, Inc.

☑ New Employee
☐ Rehire *Rehire Date*_____

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

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

**Date of Status Change:**

**Benefits Enrollment Form**

## Employee Information

| Name (Last, First, MI) | Date of Birth | Social Security Number | |
|---|---|---|---|
| ~~Timothy~~ Rivas Timothy | 2-22-79 | 524-27-3186 | |
| **Address** | **City** | **State** | **Zip Code** |
| 11115 Claude ct | Northglenn | CO | 80233 |
| **Gender** ☑ Male ☐ Female | **Marital Status** ☐ Married ☐ Single ☐ Divorced | **Phone Number:** 720.226-5522 | **Date of Hire** |

**Please Select Coverage Elected: Enhanced MEC Plan**

**Email Address:** rivastimothy69@Gmail.com

**Coverage Level :**

☑ **Single - $24.00/Week** ☐ **Employee+Spouse - $38.00/Week** ☐ **Employee+Child(ren) - $36.00/Week** ☐ **Family - $63.00/Week**

## Dependent Information

| Dependent | Sex | Birth Date | Coverage Elected | Add (Enroll) Change, or Terminate |
|---|---|---|---|---|
| Last Name First Name M.I.<br>Social Security # | ☐ Male ☐ Female | | ☐ Medical | ☐ Add ☐ Change ☐ Waive ☐ Terminate |
| **Dependent** | **Sex** | **Birth Date** | **Coverage Elected** | **Add (Enroll) Change, or Terminate** |
| Last Name First Name M.I.<br>Social Security # | ☐ Male ☐ Female | | ☐ Medical | ☐ Add ☐ Change ☐ Waive ☐ Terminate |
| **Dependent** | **Sex** | **Birth Date** | **Coverage Elected** | **Add (Enroll) Change, or Terminate** |
| Last Name First Name M.I.<br>Social Security # | ☐ Male ☐ Female | | ☐ Medical | ☐ Add ☐ Change ☐ Waive ☐ 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** Timothy Rivas **Date** 3-29-2016

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** **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

SI-IND 219301-EMP | OFFICE USE ONLY LOCATION_____ Rehire Date __/__/____

# ENROLLMENT FORM

ESC UNAV P2M v15.1

## REQUIRED EMPLOYEE INFORMATION

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

Social Security Number 524-27-3186

Date of Birth 12/22/1979 Sex (M) F

Name Timothy Rivas

Street Address 11115 Claude ct

City Northglenn State CO Zip 80233

Home Phone ~~[illegible]~~ 720 224 5522

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 + 1
- ☐ Employee + Family
- ☐ NO to all indemnity benefits.

### FIXED INDEMNITY MEDICAL

- ☑ YES — $20.91 Employee Only; $42.44 Employee + 1; $56.67 Employee + Family
- ☐ NO

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

### DENTAL

- ☑ YES — $ 6.17 Employee Only; $12.34 Employee + 1; $20.36 Employee + Family
- ☐ NO

### TERM LIFE

- ☐ YES — $0.60 Employee Only; $0.90 Employee + 1; $1.80 Employee + Family
- ☐ NO

### 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.

## 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** Timothy Rivas Date 3/29/2016