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bpa Benefit Plan Administrators, Inc.

- [x] 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	
Peters, Triston	12/15/1986	257-59-7078	
Address	**City**	**State**	**Zip Code**
3190 e 106thvpl	Northglenn	Colorado	80233

Gender	Marital Status	Phone Number:	Date of Hire
[x] Male [ ] Female	[x] Married [ ] Single [ ] Divorced	7139724123	1/15/20165

Please Select Coverage Elected: Enhanced MEC Plan

Email Address: Trpeters67@gmail. Com

Coverage Level :

[x] **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. 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. 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. 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 Triston Ryan Peters (Feb 2, 2016) Date Feb 2, 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 Feb 2, 2016

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

VSI 219301-EMP	OFFICE USE ONLY LOCATION_____	Rehire Date __/__/____

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 257-59-7078

Date of Birth 12/15/1986 Sex ☐ M ☑ F

Name Triston Ryan Peters

Street Address 3190 e 106th pl

City Northglenn State Co Zip 80233

Home Phone 7139724123

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 Emily Annette Peters

Social Security Number 642092210

Date of Birth 11241986 Sex ☐ M ☑ F

Relationship: ☑ Spouse ☐ Child ☐ Domestic Partner

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

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.

BENEFICIARY INFORMATION

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

NAME OF BENEFICIARY
Emily Annette Peters

RELATIONSHIP
Wife

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** Triston Ryan Peters (Feb 2, 2016)

Date Feb 2, 2016