



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) Miller, Tyler J.
Date of Birth 11/16/192
Social Security Number 220-37-6860
Address 11801 Washington St. Apt. F306
City Northglenn
State CO
Zip Code 80233
Gender Male
Marital Status Single
Phone Number 717-858-4444
Date of Hire 1/26/16

Please Select Coverage Elected: Enhanced MEC Plan
Coverage Level:
Single - \$24.00/Week
Employee+Spouse - \$38.00/Week
Employee+Child(ren) - \$36.00/Week
Family - \$63.00/Week
Email Address: tylermiller@gmail.com

Dependent Information

Dependent
Last Name First Name M.I.
Sex Male/Female
Birth Date
Coverage Elected Medical
Add (Enroll) Change, or Terminate

Dependent
Last Name First Name M.I.
Sex Male/Female
Birth Date
Coverage Elected Medical
Add (Enroll) Change, or Terminate

Dependent
Last Name First Name M.I.
Sex Male/Female
Birth Date
Coverage Elected Medical
Add (Enroll) Change, or Terminate

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):
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 [Signature] Date 1/26/16
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

ENROLLMENT FORM

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number 220-376861

Date of Birth 11/16/1992 Sex M F

Name Tyler J. Miller

Street Address 11801 Washington St. Apt. F306

City Northglenn State CO Zip 80233

Home Phone 717-858-4444

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 [Signature]

Date 01/26/2016