

# ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v11

### A. REQUIRED EMPLOYEE INFORMATION

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

Name Mai Yang Social Security # 614-05-3870 Home Phone \_\_\_\_\_ Sex  M  F

Address 8201 Georgia CT N. Apt. # \_\_\_\_\_

City Brooklyn Park State PARK MN Zip MN 55445 Date of Birth 10/28/1987

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

Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_  Yes  No. If Yes, please continue.

Name of Covered Person (s):  
 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Medicare Effective Date \_\_\_\_\_

### C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rate

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 BC Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>
Employee Only <input checked="" type="checkbox"/>	\$20.25 <input checked="" type="checkbox"/>	\$6.17 <input checked="" type="checkbox"/>	\$2.42 <input checked="" type="checkbox"/>	\$0.60 <input checked="" type="checkbox"/>	\$4.20 <input checked="" type="checkbox"/>
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>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 <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name _____	Social Security # _____	Date of Birth / / _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name _____	Social Security # _____	Date of Birth / / _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name _____	Social Security # _____	Date of Birth / / _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

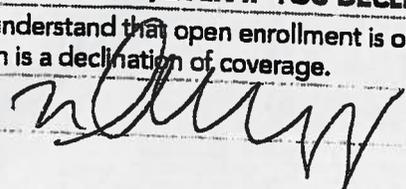
### E. REQUIRED SIGNATURE

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 08/11/2017

SIGNATURE





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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)

Mai yang

Social Security Number

614-05-3870

Address

5201 Georgia CT N.

City

Brooklyn Park MN

State

MN

Zip Code

55445

Gender

Male  
 Female

Marital Status  
 Married  
 Divorced

Single  
 Divorced

Date of Birth

Phone Number:

763-516-5354

Email Address:

tmiy@hotmail.com

Date of Hire

Please Select Desired Coverage:



Employee Only -  
\$24.00/Week



Employee+Spouse -  
\$38.00/Week



Employee+Child(ren) -  
\$36.00/Week



Family -  
\$63.00/Week

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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

*Mai Yang*

Date

8/11/17

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 or parting suit of adoption, I may be able to enroll myself or my dependant, 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