

New Employee
 Rehire *Rehire Date* _____

For Status Change Please Check: You **MUST** provide a supporting Document
 Change of Status Birth/ Spouse Loss of Coverage Plan
 Adoption Change
 Marriage Cancel Employee/Dependents
 Divorce
 Date of Status Change: _____

Benefits Enrollment Form

Employee Information			
Name (Last, First, MI) alexander, Yudora, m		Date of Birth 08221977	Social Security Number 226172911
Address 1535 syracuse ave		City Roanoke	State Va Zip Code 24017
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Divorced	Phone Number: 5402042727	Date of Hire 3/8/2016
Please Select Coverage Elected: Enhanced MEC Plan Coverage Level :		Email Address: dorachelle22@yahoo.com	
<input type="checkbox"/> Single - \$24.00/Week		<input type="checkbox"/> Employee+Spouse - \$38.00/Week	
<input checked="" type="checkbox"/> Employee+Child(ren) - \$36.00/Week		<input type="checkbox"/> Family - \$63.00/Week	

Dependent Information				
Dependent				
Alexander Antonio		Sex	Birth Date	Coverage Elected
Last Name First Name M.I. Social Security # 227776487		<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	06/22/1996	<input checked="" type="checkbox"/> Medical
Add (Enroll) Change, or Terminate <input checked="" type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate				
Dependent				
		Sex	Birth Date	Coverage Elected
Last Name First Name M.I. Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Medical
Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate				
Dependent				
		Sex	Birth Date	Coverage Elected
Last Name First Name M.I. Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Medical
Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> 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 yudora alexander Date Apr 5, 2016
yudora alexander (Apr 5, 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 Apr 5, 2016

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 2 2 6 - 1 7 - 2 9 1 1

Date of Birth 0 8 / 2 2 / 1 9 7 7 Sex M F

Name Yudora Alexander

Street Address 1535 Syracuse ave

City Roanoke State Va Zip 24017

Home Phone 540 - 204 - 2727

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 Antonio Alexander

Social Security Number 227776487

Date of Birth 06221996 / ____/____ Sex M F

Relationship: Spouse Child Domestic Partner

Name Antonio Alexander

Social Security Number 227776487

Date of Birth 06221996 / ____/____ 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.

- | | |
|--|--|
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee + Family |
| <input checked="" type="checkbox"/> Employee + 1 | <input type="checkbox"/> NO to all indemnity benefits. |

FIXED INDEMNITY MEDICAL



- | | |
|---|---------------------------|
| <input checked="" type="checkbox"/> YES | \$20.91 Employee Only |
| | \$42.44 Employee + 1 |
| <input type="checkbox"/> NO | \$56.67 Employee + Family |

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

DENTAL



- | | |
|--|---------------------------|
| <input type="checkbox"/> YES | \$6.17 Employee Only |
| | \$12.34 Employee + 1 |
| <input checked="" type="checkbox"/> NO | \$20.36 Employee + Family |

TERM LIFE



- | | |
|---|--------------------------|
| <input checked="" type="checkbox"/> YES | \$0.60 Employee Only |
| | \$0.90 Employee + 1 |
| <input type="checkbox"/> NO | \$1.80 Employee + Family |

SHORT-TERM DISABILITY



- | | |
|--|----------------------|
| <input type="checkbox"/> YES | |
| <input checked="" type="checkbox"/> 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.

BENEFICIARY INFORMATION

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

NAME OF BENEFICIARY

Antonio Alexander

RELATIONSHIP

son

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

Yudora Alexander
Yudora Alexander (Pair 2, 2016)

Date Apr 5, 2016 / ____/____