VSI **219301-ESG-1** | OFFICE USE ONLY | LOCATION _____ | Rehire Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

ESC UNACwb*MN P1 v22.0

A. REQUIRED EMPLOYEE INFORMATION

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

Name	Social Security #	Phone	Gender M F
Address			Apt. #
City	State	Zip	Date of Birth / /

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

☐ Yes ☐ No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN)		Medicare Effective Date
Name of Covered Person (s): 1.	2.	3.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Rates

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 BCS Insurance Company and 4 Ever Life Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]		DENTAL		VISION		TERM LIFE		SHORT-TERM DISABILITY [2]	
	weekly	biweekly	weekly	biweekly	weekly	biweekly	weekly	biweekly	weekly	biweekly
Employee Only	☐ **$19.96**	**$39.92**	**$6.17**	**$12.34**	**$2.42**	**$4.84**	**$0.60**	**$1.20**	**$4.20**	**$8.40**
Employee + 1	☐ **$40.51**	**$81.02**	**$12.34**	**$24.68**	**$4.92**	**$9.84**	**$0.90**	**$1.80**	-	-
Employee + Family	☐ **$54.09**	**$108.18**	**$20.36**	**$40.72**	**$6.56**	**$13.12**	**$1.80**	**$3.60**	-	-
	☐ **NO** to ALL Benefits		☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] 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 Group Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ 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 __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**