VSI **219300-ESG** | OFFICE USE ONLY | LOCATION ____________ | Rehire Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

ESC UNACwbi*MN P1 v23.1

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	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly
Employee Only ☐	$19.96	$39.92	$43.25	$6.17	$12.34	$13.37	$1.67	$3.33	$3.61	$0.60	$1.20	$1.30	$4.20	$8.40	$9.10
Employee + 1 ☐	$40.51	$81.02	$87.77	$12.34	$24.68	$26.74	$3.33	$6.66	$7.22	$0.90	$1.80	$1.95	-	-	-
Employee + Family ☐	$54.09	$108.18	$117.20	$20.36	$40.72	$44.11	$5.28	$10.57	$11.45	$1.80	$3.60	$3.90	-	-	-
NO to ALL Benefits ☐	☐ Yes ☐ No			☐ 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 reside 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	Relationship
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

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans. I understand that open enrollment is only available for a limited time; that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**