VSI 2910100-REA	OFFICE USE ONLY	LOCATION_____	Rehire Date __/__/____

ENROLLMENT FORM

ESC 4S P1M v16.0B

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number ___-__-____

Date of Birth __/__/____ Sex M F

Name _____

Street Address _____

City _____ State __ Zip ____

Home Phone ___-___-____

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

Name _____

Social Security Number ___-__-____

Date of Birth __/__/____ Sex M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

OPTION 1 - FIXED INDEMNITY PLAN — Weekly Rates

You **MUST** enroll in the Fixed Indemnity Medical Insurance Plan before adding any additional benefits. Your coverage level for the additional benefits will be identical to your fixed medical plan selection.

FIXED INDEMNITY MEDICAL

- ☐ **$19.98** Employee Only
- ☐ **$33.17** Employee + Child(ren)
- ☐ **$37.96** Employee + Spouse
- ☐ **$50.55** Employee + Family
- ☐ **NO** to all Indemnity benefits.

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

DENTAL

☐ YES ☐ NO

$ 5.40 Employee Only
$14.58 Employee + Child(ren)
$10.80 Employee + Spouse
$20.52 Employee + Family

VISION

☐ YES ☐ NO

$2.42 Employee Only
$6.54 Employee + Child(ren)
$4.84 Employee + Spouse
$9.20 Employee + Family

TERM LIFE

☐ YES ☐ NO

$0.60 Employee Only
$0.90 Employee + Child(ren)
$0.90 Employee + Spouse
$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 - MEC WELLNESS/PREVENTIVE PLAN

82910100-M-REA

Monthly Rates

- ☐ **$60.00** Employee Only
- ☐ **$79.80** Employee + Child(ren)
- ☐ **$87.00** Employee + Spouse
- ☐ **$105.90** Employee + Family
- ☐ NO to MEC Wellness/Preventive Plan

BENEFICIARY INFORMATION

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name Relationship

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 Date __/__/____