

Employer Use Only

ReHire

ReHire Date

### EMPLOYEE INFORMATION (MUST BE FILLED OUT)

226800-STW

USE BLACK or BLUE INK ONLY

Social Security Number -- Date of Birth // Sex  M  F

Name \_\_\_\_\_ Home Phone --

Street Address \_\_\_\_\_ City \_\_\_\_\_ State  Zip

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. \_\_\_\_\_ 4. \_\_\_\_\_

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 medical selection is a declination of coverage.

Signature \_\_\_\_\_ Date //

### MEDICAL BENEFIT SELECTION - 10k

Weekly Rates

- \$23.69 Employee Only
- \$48.08 Employee +1
- \$64.20 Employee + Family

For Term Life and Accidental Death & Dismemberment please write in your Beneficiary information.  
TERM LIFE / AD&D INSURANCE BENEFICIARY

RELATIONSHIP \_\_\_\_\_

No to all benefits. If checked, stop! Go no further.

AD&D is part of the Medical Benefits

- You **MUST** enroll in the Medical Insurance Plan before adding any additional benefits.
- Your coverage level for the additional benefits will be identical to your medical plan selection.
- For questions regarding benefits, please call Essential StaffCARE Customer Service at 1-866-798-0803.

### SUPPLEMENTARY BENEFITS

Weekly Rates

	Yes	No	Employee Only	Employee +1	Employee + Family
<b>DENTAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	\$5.23	\$10.46	\$17.26
<b>VISION</b>	<input type="checkbox"/>	<input type="checkbox"/>	\$2.35	\$ 4.00	\$ 5.64
<b>TERM LIFE</b>	<input type="checkbox"/>	<input type="checkbox"/>	\$0.60	\$ 0.90	\$ 1.80
<b>SHORT-TERM DISABILITY</b>	<input type="checkbox"/>	<input type="checkbox"/>	\$4.20	STD is an Employee Only plan	

Short-Term Disability (STD) is not available to persons who work in California, Hawaii, New Jersey, New York, and Rhode Island.

### Required Dependent Information

Name \_\_\_\_\_ Relationship:  Spouse  Domestic Partner  Child

Social Security Number -- Date of Birth // Sex  M  F

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**KEEP FOR YOUR RECORDS**

Group Number 226800 - STW

Coverage will begin the Monday following a payroll deduction. After 6 months if there has not been a deduction from your paycheck, please fill out a new enrollment form. Missing information will delay the process.

<b>Medical/Rx Benefits</b>		<b>Beech Street Network <a href="http://www.beechstreet.com">www.beechstreet.com</a></b>		
Annual Maximum Benefit (per person, all expenses)	\$10,000	Individual Annual Deductible	\$200	
Annual Outpatient Maximum	\$1,500	Family Annual Deductible	\$500	
Annual Maximum on Other Hospital Services	\$1,500	Daily Room & Board Maximum	\$400	
Coinsurance* (in-network or out-of-network)	80%	Daily ICU Room & Board	\$800	
Doctor's Office Visits (deductible does not apply)	100% of bill after a \$15 co-pay (subject to outpatient limit)			
Wellness Benefit	\$100 Annual Maximum after a \$15 co-pay (not subject to annual maximum)			
<b>Prescription Drug Benefit</b>		<b>Caremark Network <a href="http://www.caremark.com">www.caremark.com</a></b>		
\$50 per month (no carryover)	\$10 co-pay Generic	\$30 co-pay Branded		
<b>Accidental Death and Dismemberment Benefit (part of the Medical Benefits)</b>				
Employee Amount	\$10,000/Reduces to \$7,500 at 65, \$5,000 at age 70			
Spouse Amount	\$5,000			
Child Amount (6 months to 24 years old)	\$5,000			
Infant Amount (15 days to 6 months)	\$1,000			
<b>Weekly Rates</b>	Employee Only <b>\$23.69</b>	Employee Plus One <b>\$48.08</b>	Employee Plus Family <b>\$64.20</b>	
<b>Dental Benefits</b>		<b>DenteMax Network <a href="http://www.dentemax.com">www.dentemax.com</a></b>		
Annual Maximum Benefit	\$750	Deductible	\$50	
	<b>Waiting Period</b>	<b>Coinsurance</b>		
Coverage A	none	80%	Exams, Intraoral Films and Bitewings	
Coverage B	3 months	60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures	
Coverage C	12 months	50%	Periodontics, Crowns, Bridges, Endodontics and Dentures	
<b>Weekly Rates</b>	Employee Only <b>\$5.23</b>	Employee Plus One <b>\$10.46</b>	Employee Plus Family <b>\$17.26</b>	
<b>Vision Benefits</b>		<b>Cole Managed Network <a href="http://www.colemanagedvision.com">www.colemanagedvision.com</a></b>		
	<b>Frequency</b>	<b>Coinsurance</b>	<b>Deductible</b>	<b>Maximum Benefit</b>
Eye Examination for Glasses	1 visit per 12 months	80%	\$5 per visit	\$25
Choice A: Eye Glasses				
Lenses	2 lenses per 12 months	75%	\$15 per purchase	\$35-\$75
Frames	1 pair per 12 months	75%	\$15 per purchase	\$25
Choice B: Contact Lenses	2 lenses per 12 months	75%	\$15 per purchase	\$95
Choice C: Disposable Lenses	Up to a 12 month supply per 12 months	75%	\$15 per purchase	\$75
<b>Weekly Rates</b>	Employee Only <b>\$2.35</b>	Employee Plus One <b>\$4.00</b>	Employee Plus Family <b>\$5.64</b>	
<b>Short-Term Disability Benefits</b>				
Benefit	60% of salary up to \$150 per week			
Waiting Period and Maximum Benefit Period	7 days / 26 weeks			
<b>Employee Only Weekly Rate</b>	<b>\$4.20</b>			
<b>Term Life Benefits</b>				
Employee Amount	\$10,000/Reduces to \$7,500 at 65, \$5,000 at age 70			
Spouse Amount	\$5,000/Terminates at age 70			
Child Amount (6 months to 24 years old)	\$5,000			
Infant Amount (15 days to 6 months)	\$1,000			
<b>Weekly Rates</b>	Employee Only <b>\$0.60</b>	Employee Plus One <b>\$0.90</b>	Employee Plus Family <b>\$1.80</b>	

\*subject to annual deductible

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.