



WES



Essential StaffCARE

Complete the Enrollment Form to Elect or Decline Coverage

Health Insurance Enrollment Form

- You **MUST** Complete the Enrollment Form for New Hire Process
 - You **MUST** Elect or Decline Coverage on Enrollment Form
 - Tear Off this Page and Return to Branch Manager
 - Keep the rest of the Packet for Your Records and Plan Information
-

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.



"The quality choice for professional placement services."

The Essential StaffCare Medical/Rx, Accidental Death and Dismemberment, and Dental are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 24.220, and 26.212.

Form: ESC 5k NVTY v7.5

EMPLOYEE INFORMATION (MUST BE FILLED OUT) 2051 - WES

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 - 5k Weekly Rates

| | |
|---|--|
| <input type="checkbox"/> \$19.98 Employee Only <input type="checkbox"/> \$40.54 Employee +1 <input type="checkbox"/> \$54.14 Employee + Family <input type="checkbox"/> No to all benefits. If checked, stop! Go no further. | For Accidental Death & Dismemberment please write in your Beneficiary information. AD&D INSURANCE BENEFICIARY _____ RELATIONSHIP _____ AD&D is part of the Medical Benefits |
|---|--|

- You **MUST** enroll in the Medical Insurance Plan before adding any dental benefits.
- Your coverage level for the dental 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

| | | | | |
|---------------|--|-------------------------|------------------------|------------------------------|
| DENTAL | <input type="checkbox"/> Yes <input type="checkbox"/> No | Employee Only \$5.23 | Employee +1 \$10.46 | Employee + Family \$17.26 |
|---------------|--|-------------------------|------------------------|------------------------------|

Required Dependent Information

| | |
|---|--|
| Name _____ | Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child |
| Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/> | Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Name _____ | Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child |
| Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/> | Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Name _____ | Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child |
| Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/> | Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Name _____ | Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child |
| Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/> | Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> Sex <input type="checkbox"/> M <input type="checkbox"/> F |

KEEP FOR YOUR RECORDS

Group Number 2051 - WES

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.

| Medical/Rx Benefits | | Beech Street Network www.beechstreet.com | |
|--|--|--|-------|
| Annual Maximum Benefit (per person, all expenses) | \$5,000 | Individual Annual Deductible | \$200 |
| Annual Outpatient Maximum | \$2,000 | Family Annual Deductible | \$500 |
| Annual Maximum on Other Hospital Services | \$1,000 | Daily Room & Board Maximum | \$200 |
| Coinsurance* (in-network or out-of-network) | 80% | Daily ICU Room & Board | \$400 |
| 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) | | |

| Prescription Drug Benefit | | Caremark Network www.caremark.com | |
|---|--|--|--|
| 80% Coinsurance* (subject to annual outpatient maximum) | | | |

| Accidental Death and Dismemberment Benefit (part of the Medical Benefits) | | | |
|--|--|----------------------------------|-------------------------------------|
| 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 | | |
| Weekly Rates | Employee Only \$19.98 | Employee Plus One \$40.54 | Employee Plus Family \$54.14 |

| Dental Benefits | | DenteMax Network www.dentemax.com | |
|------------------------|-----------------------------|--|--|
| Annual Maximum Benefit | \$750 | Deductible | \$50 |
| | Waiting Period | Coinsurance | |
| 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 |
| Weekly Rates | Employee Only \$5.23 | Employee Plus One \$10.46 | Employee Plus Family \$17.26 |

*subject to annual deductible

To receive additional information, obtain answers to your questions, or to enroll in this plan, call (866) 798-0803.

To access doctors or verify coverage before receiving your ID card, supply your provider with the following information: your name, customer service number (866) 798-0803 and your Member ID number.

("creditable coverage"), if there is no more than a 62-day break in coverage. You should give us a copy of any certificates of creditable coverage. If you do not have a certificate, but have prior health coverage, we will help you obtain one from your prior plan. There are also other ways to demonstrate you have creditable coverage, so contact us if you need help. All questions about the pre-existing condition exclusion and creditable coverage should be directed to: Essential StaffCARE Unit Supervisor, Planned Administrators, Incorporated (PAI), P.O. Box 6702, Columbia, SC 29260, or call us at: (866) 798-0803.

Important Information: This is a limited benefit medical insurance plan, renewable at the option of the policyholder. This is not major medical insurance. You will receive your health insurance ID card in the mail and information on how to access your Summary Plan Description (SPD). This plan is an employer sponsored benefit; it cannot be purchased as an individual policy. If you are age 65 or older or if you or your dependents are eligible for Medicare and you are enrolled in Essential StaffCARE contact your Human Resource Department for the Medicare Part-D notice. To avoid a break in coverage you may make direct payments to PAI. After six consecutive weeks without a payroll deduction or direct premium payment, coverage will be terminated and COBRA information will be sent at that time.

How to make changes or cancel coverage by telephone

Call (800) 269-7783 within 30 days to make changes or cancel coverage by telephone. You will be prompted to enter your **PIN CODE plus the last four digits of your Social Security number (SSN)**. You may cancel or reduce coverage at any time unless your deductions are pre-tax. Remember, it may take up to two or three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction.

PIN CODE: 140 _ _ _ _ (last four digits of your SSN)

Limited benefit medical plan: This benefit packet is intended as a brief summary of the Essential StaffCARE Limited Benefit Medical Plan. The group policy issued to your employer is the official document governing the provisions of this plan. State mandated benefits that apply to this plan will be included even if they are not described in this benefit packet.

Exclusions and Limitations*

Medical: No benefits will be paid for losses caused by mental or nervous disorders, alcoholism or substance abuse treatment (may vary by state); intentionally self-inflicted injuries, suicide or any attempt; declared or undeclared war; or serving on full-time active duty in the Armed Forces; covered person's commission of a felony; flying as a pilot or crew member of any aircraft; work-related injury or sickness. Applicable only to Accidental Death and Dismemberment: Bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of a poisonous food substance.

No benefits will be paid for eye or hearing exams; hearing aids; normal health checkups other than those covered under the Wellness benefit; treatment in US government hospital or facility; dental care or treatment other than care of natural teeth and gums resulting from an accident; cosmetic surgery; services provided by an immediate family member.

Pre-existing conditions: No benefits will be paid for a pre-existing condition (one you had treatment for within the six month period ending the day before your enrollment date) for the first 12 months of your coverage (may vary by state). This does not apply to pregnancy nor to a newborn or adopted child covered from birth or adoption. The exclusion period may be reduced by most previous medical expense coverage

*As limitations and exclusions may vary by state, please see your Summary Plan Description (SPD) for a detailed listing.