Health Insurance Enrollment Form
Complete the Enrollment Form to Elect or Decline Coverage

• Complete the Enrollment Form for the New Hire Process
• Elect or Decline Medical Coverage on the Enrollment Form
• You MUST Sign and Date the Bottom of the Form, even if you Decline Coverage
• Return the Enrollment Form to your Branch Manager

This plan does not qualify as minimum essential coverage as defined under the Affordable Care Act (ACA). This plan is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

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.

For Enrollees of California employer policies: In order to enroll in the Fixed Indemnity Medical Benefit, you must be enrolled in major medical coverage.


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

SELECT COVERAGE LEVEL

You MUST select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.

☐ Employee Only ☐ Employee + Spouse
☐ Employee + Child(ren) ☐ Employee + Family
☐ NO to all Benefits

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name ____________________________________________
Relationship ______________________________________

BENEFIT BUNDLE

The benefit bundle includes dental, vision, and term life benefits.

☐ YES $8.42 Employee Only
☐ YES $16.62 Employee + 1
☐ NO $26.18 Employee + Family

FIXED INDEMNITY PLAN

Weekly Rates

☐ YES $19.58 Employee Only
☐ YES $39.73 Employee + 1
☐ NO $53.06 Employee + Family

This is a supplement to health coverage and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

I hereby attest that I am purchasing this policy as a supplement or in addition to other major medical health insurance coverage.

☐ YES ☐ NO

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 __/__/_________
## BENEFITS AT A GLANCE

| Policy Number       | 208700-CEG |

### Fixed Indemnity Medical Plan

<table>
<thead>
<tr>
<th>Network Information</th>
<th>First Health Network</th>
<th>1-800-226-5116</th>
<th><a href="http://www.firsthealth.com">www.firsthealth.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Network</td>
<td>EyeMed Vision Care</td>
<td>1-866-559-5252</td>
<td><a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a></td>
</tr>
<tr>
<td>Dental Network</td>
<td>DenteMax</td>
<td>1-800-752-1547</td>
<td><a href="http://www.dentemax.com">www.dentemax.com</a></td>
</tr>
</tbody>
</table>

### Inpatient Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-insurance</th>
<th>Annual Maximum Benefit</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Care</td>
<td>80%</td>
<td>$300 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Intensive Care Unit Maximum</td>
<td>60%</td>
<td>$400 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>50%</td>
<td>$2,000 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>50%</td>
<td>$400 per day</td>
<td>$50</td>
</tr>
<tr>
<td>First Hospital Admission (1 per year)</td>
<td>80%</td>
<td>$250</td>
<td>$50</td>
</tr>
<tr>
<td>Skilled Nursing (for stays in a skilled nursing facility after a hospital stay)</td>
<td>100%</td>
<td>$100 per day</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Outpatient Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-insurance</th>
<th>Annual Maximum Benefit</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Outpatient Maximum</td>
<td>100%</td>
<td>$2,000</td>
<td>$50</td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>100%</td>
<td>$100 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Diagnostic (Lab)</td>
<td>100%</td>
<td>$75 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Diagnostic (X-Ray)</td>
<td>100%</td>
<td>$200 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>100%</td>
<td>$300 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Physical Therapy, Speech Therapy, Occupational Therapy</td>
<td>100%</td>
<td>$50 per day</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Wellness Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-insurance</th>
<th>Annual Maximum Benefit</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Benefit - Sickness</td>
<td>100%</td>
<td>$200 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Emergency Room Benefit - Accident</td>
<td>100%</td>
<td>$500 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>100%</td>
<td>$500 per day</td>
<td>$50</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>100%</td>
<td>$200 per day</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Dental Benefits

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Waiting Period</th>
<th>Co-insurance</th>
<th>Annual Maximum Benefit</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>None</td>
<td>80%</td>
<td>Exams, Cleanings, Intraoral Films and Bitewings</td>
<td>$50</td>
</tr>
<tr>
<td>B</td>
<td>3 Months</td>
<td>60%</td>
<td>Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures</td>
<td>$50</td>
</tr>
<tr>
<td>C</td>
<td>12 Months</td>
<td>50%</td>
<td>Periodontics, Crowns, Bridges, Endodontics and Dentures</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Vision Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination for Glasses (including dilation)</td>
<td>Copay: $10, plan pays 100%</td>
<td>Plan pays $35, you pay remainder</td>
</tr>
<tr>
<td>Frames</td>
<td>Plan pays $110 allowance 4</td>
<td>Plan pays $55</td>
</tr>
<tr>
<td>Standard Plastic Lenses for Glasses 1</td>
<td>Copay: $25, plan pays 100%</td>
<td>Copay: $0, plan pays $25-$55 3</td>
</tr>
<tr>
<td>Standard Contact Lens Fit 1</td>
<td>Plan pays up to $55</td>
<td>You pay 100% of the price</td>
</tr>
<tr>
<td>Premium Contact Lens Fit 1</td>
<td>Plan pays 10% off the price</td>
<td>You pay 100% of the price</td>
</tr>
<tr>
<td>Contact Lenses or Disposable Lenses 1</td>
<td>Plan pays $110 allowance 4</td>
<td>Plan pays $88</td>
</tr>
<tr>
<td>Contact Lenses Medically Necessary 1</td>
<td>Plan pays 100%</td>
<td>Plan pays $200</td>
</tr>
</tbody>
</table>

### Fixed Indemnity Medical Plan Notes:
- All outpatient benefits are subject to the outpatient maximum.
- Pays in addition to standard care benefit.
- Covers treatment for off the job accidents only.

### Term Life Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Amount</td>
<td>$10,000 (reduces to $7,500 at 65; $5,000 at 70)</td>
</tr>
<tr>
<td>Child Amount (6 mos to 26 yrs old)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Spouse Amount</td>
<td>$5,000 (terminates at age 70)</td>
</tr>
<tr>
<td>Infant Amount (15 days to 6 mos)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Accidental Death & Dismemberment

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Amount</td>
<td>$20,000</td>
</tr>
<tr>
<td>Child Amount (6 mos to 26 yrs old)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Spouse Amount</td>
<td>$20,000</td>
</tr>
<tr>
<td>Infant Amount (15 days to 6 mos)</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

### Weekly Premium

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Medical</th>
<th>Benefit Bundle: Dental, Vision, Term Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$19.58</td>
<td>$8.42</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$39.73</td>
<td>$16.62</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$53.06</td>
<td>$26.18</td>
</tr>
</tbody>
</table>
EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

FIXED INDEMNITY MEDICAL

No benefits will be paid for loss caused by or resulting from:

• Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
• Declared or undeclared war
• Serving on full-time active duty in the armed forces
• The covered person's commission of a felony
• Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law or

No benefits will be paid for:

• Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
• Hearing examinations or hearing aids
• Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
• Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
• Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

VISION

No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

TERM LIFE WITH ACCIDENTAL DEATH & DISMEMBERMENT

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

• Attempted suicide or intentionally self inflicted injury; 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 poisonous food substance; voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you, your spouse or domestic partner; you, your spouse's or domestic partner's child; sibling or parent; or a person who resides in your home; declared or undeclared war or act of war; your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony; your participation in a riot; if you engage in an illegal occupation; release of nuclear energy; operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; work-related injury or sickness.

Member Services:

For questions regarding when and how you can enroll/make changes, as well as additional frequently asked questions, please go to www.essentialstaffcare.com/FAQCA for this information.

PLEASE NOTE: Your Company has chosen to take your payroll deductions on a Post-Tax basis.

Essential StaffCARE Customer Service: 1-866-798-0803
• Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets and to add, change, or cancel coverage.
• Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
• Members can also visit www.paisc.com and click on “Members” and enter your group number.