REQUIRED: COMPANY USE ONLY

Date of Hire	*Effective Date*	*Occupation / Title*	*Salary*	*Pay Frequency*
				☐ Weekly | ☐ Semi-Monthly ☐ Bi-Weekly | ☐ Monthly

ENROLLMENT/ELECTION INFORMATION

REASON FOR ENROLLMENT: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event ☐ Re-Hire

COMPANY PROVIDED INSURANCE: ☒ Short-Term Disability ☒ Long-Term Disability ☒ Basic Life & AD&D Insurance

ELECTIVE INSURANCE SELECTED: ☐ Medical ☐ Dental ☐ Vision (see page 2 for selections)

WAIVE COVERAGE: ☐ Medical ☐ Dental ☐ Vision Reason for Declining:

STATUS CHANGE: ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination

EMPLOYEE INFORMATION REQUIRED

Employee's Full Name (FIRST MI LAST)	**Date of Birth**	**SS#**

Home Address ☐ **Update address**	**City**	**State**	**Zip**	**HMO/PCP#**

Home Phone	**Work Phone**	**Email Address** ☐ **Work** ☐ **Personal**

Gender ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married	☐ **Tobacco** ☐ **Non-Tobacco**	**Date of Qualifying Event**

DEPENDENTS TO BE COVERED

Name of Person to be Covered Last First MI	**SS #**	**Gender**	**Date of Birth**	**HMO/PCP#**
Spouse		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		

COMPANY-PROVIDED INSURANCE

FEM Centre provides eligible full-time employees Basic Life & AD&D insurance coverage of $50,000, Short-Term and Long-Term Disability.

INSURANCE BENEFICIARY DESIGNATION (COMPLETE EVEN IF OTHER BENEFITS ARE WAIVED)

Primary Beneficiary Name	**Relationship**	**Social Security Number**	**% of Assets**	**Beneficiary Address** (if different from yours)
Contingent Beneficiary Name	**Relationship**	**Social Security Number**	**% of Assets**	**Beneficiary Address** (if different from yours)

Bi-Weekly Cost	MEDICAL PLAN PPO OPTIONS		
Plan *(Choose One)*	☐ **PPO – S661CHC**	☐ **PPO – G654CHC**	☐ **PPO – P620CHC**
☐ Waive Coverage	NA	NA	NA
☐ Employee Only	$ 302.49	$ 437.47	$ 582.08
☐ Employee & Spouse	$958.05	$1,228.02	$1,517.24
☐ Employee & Child(ren)	$958.05	$1,228.02	$1,517.24
☐ Employee & Family	$1,613.62	$1,613.62	$2,452.40

Bi-Weekly Cost	MEDICAL PLAN HMO OPTIONS			
	☐ **HMO – S642ADT No Out-of-Network Coverage**	☐ **HMO – G664ADT No Out-of-Network Coverage**	☐ **HMO – P610ADT No Out-of-Network Coverage**	**HMO** – Must Select PCP Insert Primary Care Physician's Name & HMO Number
☐ Waive Coverage	NA	NA	NA	
☐ Employee Only	$ 86.40	$ 152.95	$ 266.88	
☐ Employee & Spouse	$ 525.89	$ 658.98	$ 886.84	
☐ Employee & Child(ren)	$ 525.89	$ 658.98	$ 886.84	
☐ Employee & Family	$965.37	$1,165.00	$1,506.79	
Reason for Declining: ☐ Cost ☐ Other Coverage ☐ Other (please describe)				

DENTAL PLAN		
Plan *(Choose One)*	☐ DHMO	☐ PPO
☐ Waive Coverage	NA	
☐ Employee Only	$0.00	$13.40
☐ Employee & Spouse	$4.48	$32.91
☐ Employee & Child(ren)	$8.19	$40.24
☐ Employee & Family	$13.08	$59.76
DHMO Provider:		

VISION PLAN VSP	
☐ Waive Coverage	NA
☐ Employee Only	$0.00
☐ Employee Plus One	$6.72
☐ Employee & Family	$9.93

IMPORTANT

I understand and have verified the benefit selections I have made and authorize my employer to deduct any payroll deductions required for these selections. I also understand that the above selections for medical, dental, and vision (which are all pre-tax deductions) may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I understand that, by participating in any pre-tax plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. I also have read and understand the enrollment provisions, including restrictions stated on this form.

Details of each plan are contained in various insurance contracts and other legal documents. In the event of a conflict the contracts and plan documents prevail.

Compliance information located on www.insuranceisboring.com. Username: benefits@femcentre.com Password: FEM

Print Name: _____ Signature _____ Date _____

DIGITAL COPY:

BCBS of Texas Provider Finder:
www.bcbstx.com
Click on "Find a Doctor or Hospital" Fill in your state and Click on "Search as Guest"
Click on "Search In-Network Providers"
Select one of the following under the Plans dropdown
~For the PPO plan, select "Blue Choice PPO [BCA]
~For the HMO plan, select "Blue Advantage HMO [BAV]
Select your "Browse By" option or search provider's name.
For the HMO plans, select a provider from the list. Provide their PCP# (alpha-numeric) with your plan election

Sun Life Dental Provider Finder
www.sunlifedentalbenefits.com/find-a-dentist/

Sun Life Vision Provider Finder
www.vsp.com/eye-doctor