

Benefit Plan 1 - Base MV - DM/GM



First Name

Last Name

Marital Status

Email

Phone

Address

City

State

ZIP

Date of Birth

SSN

Hire Date

Tobacco Use (Yes / No)

Included benefits

- ☒ **Base MV**
Affordable coverage that includes physician and inpatient services
- ☒ **Hospital Services**
Affordable copays for inpatient, outpatient, and ER
- ☒ **Additional Services**
Includes coverage for Chiropractic, Emergency Transport, and more
- ☒ **Unlimited Telemedicine**
Health care without the in-person visit

Select your plan type

- ☐ **Employee Only \$268.76/mo**
- ☐ **Employee + Spouse \$581.30/mo**
- ☐ **Employee + Child(ren) \$530.47/mo**
- ☐ **Family \$799.76/mo**

Enter Dependent Names

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

First Name

Last Name

Gender

Relationship

Date of Birth

SSN



Would You Like To Enroll In Additional Benefits?

☐ Yes ☐ No

Comprehensive Dental Coverage

- ☐ Employee Only: \$25.58/month
- ☐ Employee + Spouse: \$73.62/month
- ☐ Employee + Child(ren): \$68.89/month
- ☐ Employee + Family: \$124.41/month
- ☐ No Coverage

Vision Coverage

- ☐ Employee Only: \$7.48/month
- ☐ Employee + Spouse: \$19.42/month
- ☐ Employee + Child(ren): \$20.42/month
- ☐ Employee + Family: \$36.37/month
- ☐ No Coverage

Enter Dependent Names

First Name	Last Name	Gender
Relationship	Date of Birth	SSN

First Name	Last Name	Gender
Relationship	Date of Birth	SSN

First Name	Last Name	Gender
Relationship	Date of Birth	SSN

First Name	Last Name	Gender
Relationship	Date of Birth	SSN

First Name	Last Name	Gender
Relationship	Date of Birth	SSN

Authorization and Request for Coverage

I hereby enroll or decline as indicated above in the benefits for which I am eligible.

I acknowledge and understand that the cost for any and all benefits I enroll in will be deducted from my payroll.

Total Cost

Signature