

Benefit Plan 2 - EliteCare MEC w/ Nat Select - PT



First Name	Last Name	Marital Status	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email	Phone		
<input type="text"/>	<input type="text"/>		
Address	City	State	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	SSN	Hire Date	Tobacco Use (Yes / No)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Included benefits

- EliteCare MEC w/ National Select**
Unlimited visits for PCP, Urgent Care, and ER
- Companion Discount Card**
Savings for the whole household
- Hospital Indemnity**
Helps pay out-of-pocket costs for admissions

Select your plan type

- Employee Only \$224.00/mo**
- Employee + Spouse \$429.00/mo**
- Employee + Child(ren) \$404.00/mo**
- Family \$591.00/mo**

Enter Dependent Names

First Name	Last Name	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship	Date of Birth	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>

First Name	Last Name	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship	Date of Birth	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>

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Relationship	Date of Birth	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>

First Name	Last Name	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship	Date of Birth	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>

Burger King/Jersey Mikes - Additional Benefits - PT



Would You Like To Enroll In Additional Benefits?

Yes No

Comprehensive Dental Coverage

- Employee Only: \$51.15/month
- Employee + Spouse: \$99.20/month
- Employee + Child(ren): \$94.47/month
- Employee + Family: \$149.99/month
- No Coverage

Vision Coverage

- Employee Only: \$14.95/month
- Employee + Spouse: \$26.90/month
- Employee + Child(ren): \$27.90/month
- Employee + Family: \$43.85/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
