

# Benefit Plan 4 - Premium MV - 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

- Pregnancy Services
- Substance Abuse Treatment
- Unlimited Telemedicine
- Physical, Speech & Occupational Therapy

## Select your plan type

- Employee Only \$643.49/mo
- Employee + Spouse \$1,054.46/mo
- Employee + Child(ren) \$937.66/mo
- Family \$1,210.20/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"/>

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"/>

# 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

\_\_\_\_\_