2020-2021 Enrollment Form

Employee Number :		Date :	

Purpose - Dates Required

- ❑ New Hire
- ❑ Re-Hire Date:_____
- ❑ Part Time to Full Time
  Date FT: _____
  Effective Date of QE: _____
- ❑ Qualifying Event
- ❑ Add Dependent
- ❑ Terminate Dependent
- ❑ Terminate - Other Coverage
- ❑ Reduction of Hours
- ❑ Name Change
- ❑ Address Change
- ❑ Salary Change
- ❑ Plan Change
- ❑ Going on Medicare

Reason: ❑marriage ❑divorce ❑birth ❑death
❑court order** ❑adoption** ❑loss/gain of coverage** **provide supporting documents

Employee Information

_____ _____ _____
Employee Name (Last, First, Middle) *DOB* *SSN*

_____ _____ _____ _____
Current Home Address (Street, Apt#) *City* *State* *Zip*

Home Phone # _____ ❑Male ❑Female ❑Single ❑Married

Email address _____ Job Title:_____ Job Class:_____

Salary $:_____ ❑Hourly ❑Weekly ❑Monthly ❑Annual

Must complete application in **FULL** or it will be returned resulting in a delay in processing. You are solely responsible for its accuracy and completeness. Enrollment must occur within 30 days from the date the employee becomes eligible.

Dependent Information (covered dependents only)

Names of Covered Family Members	Gender		DOB	SSN
Spouse:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		

Medical (per pay period)

Cigna **Group # 609548**

HSA with HRA LocalPlus or OAP

- ❑ Employee Only $94.83
- ❑ Employee + Spouse $372.02
- ❑ Employee + Child(ren) $288.18
- ❑ Employee + Family $586.16

PPO with HRA OAP

- ❑ Employee Only $181.91
- ❑ Employee + Spouse $571.44
- ❑ Employee + Child(ren) $500.62
- ❑ Employee + Family $890.18

❑ Waive

HSA Deductions (per pay period)

HSA Plan Contribution

Please Note: It is your responsibility to ensure you are eligible to contribute and that you do not exceed the maximum contribution allowed

- ❑ Single $_____ per pay period *(Annual IRS Contribution limit 2020 - $3,550 / 2021 - $3,600)*
- ❑ Family $_____ per pay period *(Annual IRS Contribution limit 2020 - $7,100 / 2021 - $7,200)*
- ❑ Over 55 catch up $_____ per pay period *(Annual IRS Contribution limit $1,000)*
- ❑ Waive

Dental (per pay period)

Cigna **Group # 609548**

Core PPO

- ❑ Employee Only $15.99
- ❑ Employee + Spouse $31.54
- ❑ Employee + Child(ren) $40.97
- ❑ Employee + Family $56.54
- ❑ Waive

Buy-Up PPO

- ❑ Employee Only $23.26
- ❑ Employee + Spouse $46.82
- ❑ Employee + Child(ren) $60.09
- ❑ Employee + Family $83.68

DHMO

- ❑ Employee Only $6.44
- ❑ Employee + Spouse $10.83
- ❑ Employee + Child(ren) $13.57
- ❑ Employee + Family $19.20

Selected DHMO provider:_____

***If you are electing the DHMO and do not list a provider one will be chosen for you. If you wish to change providers at any time you may do so by calling customer service by the 15th of the month and to be effective on the 1st of the following month.**

Vision (per pay period)

Cigna **Group # 609548**

Vision Plan

- ❑ Employee Only $3.54
- ❑ Employee + Spouse $7.05
- ❑ Employee + Child(ren) $6.70
- ❑ Employee + Family $10.51
- ❑ Waive

Employee Name (Last, First, Middle) | *DOB* | *SSN*

Basic Term Life & AD/D (Employer Paid)

Cigna **Group # 609548**

- Benefit Amount $25,000

Primary Beneficiary Designation

Please Note: If no beneficiary is designated, assets will be payable to the Estate of the insured.

Full Name	DOB	Relationship	SSN	% of Assets

Contingent Beneficiary Designation

Full Name	DOB	Relationship	SSN	% of Assets

Voluntary Term Life (Monthly)

Cigna YOU MUST ELECT COVERAGE FOR YOURSELF IN ORDER TO COVER YOUR DEPENDENTS **Group # 609548**

Employee Life Options:

- ❑ $10,000 ❑ $40,000 ❑ $70,000 ❑ **$100,000 ***
- ❑ $20,000 ❑ $50,000 ❑ $80,000 ❑ *Other Amount $*_____ (anything over $100,000 will require additional medical information)
- ❑ $30,000 ❑ $60,000 ❑ $90,000
- ❑ Waive

Life: *(per $1,000 of benefit)* **Maximum of $300,000; Not to exceed 5x annual salary**

25-29 $0.102	40-44 $0.215	55-59 $0.794	70-74 $3.712
30-34 $0.111	45-49 $0.305	60-64 $1.240	75-79 $5.813
35-39 $0.135	50-54 $0.479	65-69 $2.036	80+ $99.150

Spouse Life Options:

- ❑ $5,000 ❑ **$20,000 ***
- ❑ $10,000 ❑ *Other Amount $*_____ (anything over $20,000 will require additional medical information)
- ❑ $15,000
- ❑ Waive

Life: *(per $1,000 of benefit)* **Maximum of $150,000; Not to exceed 50% of employee election**

25-29 $0.102	40-44 $0.215	55-59 $0.794	70-74 n/a
30-34 $0.111	45-49 $0.305	60-64 $1.240	75-79 n/a
35-39 $0.135	50-54 $0.479	65-69 $2.036	80+ n/a

Child Life Options:

- ❑ $10,000

Life: *(per $1,000 of benefit)*

Life	$0.095

- ❑ Waive

Short Term Disability (Employer Paid)

Cigna **Group # 609548**

- Weekly Benefit Amount: 60% of Salary to $2,300

Long Term Disability (Employer Paid)

Cigna **Group # 609548**

- Monthly Benefit Amount: 60% of Salary to $6,000

Consumerism Card (per month)

New Benefits

Dental, TelaDoc, Hearing Aids, Lab & Imaging, Medical Bill Saver, Medical Health Advisor, Pharmacy, Travel Assistance, Vision, Vitamins & Diabetic Supplies

❑ $10.00 per month ❑ Waive

Disclosures: This plan is NOT insurance. This plan provides discounts at certain healthcare providers for medical services. This plan does not make payments directly to the providers of medical services. The plan member is obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have contracted with the discount plan organization. **This discount card program contains a 30 day cancellation period.** FL, LA MD, MS, ND, OK, SC, SD and TX residents: A refund of all fees will be issued if membership is cancelled within the first 30 days. MA Residents: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L.c. 111M and 956 CMR 5.00 **Discount Medical Plan Organization**: New Benefits, Ltd. Attn: Compliance Department P O Box 671309, Dallas, TX 75367-1309 (800)800-7616. A list if providers in your area is available at www.locateproviders.com

Supplemental Plans

Sun Life

***Sun Life Supplemental Insurance Plans* - See benefit guide for plan options**

I verify that the information provided in this enrollment form is accurate and complete. I understand that if I have declined Voluntary Life and request to purchase such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) the insurance carrier will have the right to refuse my request.

I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan (Section 125), and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or if I experience a significant change in family status (called a "Life Event") such as, gaining or losing dependents through Birth, Death, Marriage, Divorce, or gaining or losing other health coverage, etc. I understand that I must make any changes within 30 days of the approved "Life Event." I understand that by not applying for the coverages contained herein, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for approval. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed. Additionally, I agree, for myself and for any eligible dependent listed, to abide by the rules and regulations of the plan, terms and conditions of all the Service Agreements for the Plans I have elected.

Employee Signature *Date*

LegalShield

Corporate Offices: One Pre-Paid Way • Ada, OK 74820
www.LegalShield.com • 800-654-7757

LegalShield is the trade name of Pre-Paid Legal Services, Inc. and its subsidiaries.

Select Applicable Subsidiary:

- ○ Pre-Paid Legal Services, Inc.
- ○ Pre-Paid Legal Casualty, Inc.
- ○ Legal Service Plans of Virginia, Inc.
- ○ Pre-Paid Legal Services, Inc. of Florida
- ○ Pre-Paid Legal Access, Inc.

OFFICE USE ONLY			
CWA		PLAN	
FOB		FRAN	
MODE		GR#	

EMPLOYEE BENEFIT MEMBERSHIP APPLICATION

Today's Date ___/___/_____ (MM / DD / YYYY) **Time of Day** _____ ○ A.M. ○ P.M.

A $10 non-refundable fee ($25 for CDLP) is waived due to your employer offering this at work.
Home Business Supplement members should attach a document and provide:
1) business name, **2)** tax identification number, and
3) a general description of the business.

Please Choose plan:

	Plan		Family Price		Individual Price
☐	LegalShield	☐	$7.48	☐	$7.98
☐	IDShield	☐	$7.98	☐	$4.23
☐	Combined	☐	$14.45	☐	$11.70

1 Personal Information

The information you provide on this application is considered non-public information and LegalShield takes care to protect your information.

○ Mr. ○ Mrs. ○ Ms. **Applicant's SSN** _____ (For Internal Use Only) **DOB** ___/___/_____ (MM / DD / YYYY)

Applicant's Name _____ (Last) _____ (First) _____ (MI)

****Email** _____

***Co-Applicant's Name** _____ (Last) _____ (First) _____ (MI) **DOB** ___/___/_____ (MM / DD / YYYY)

****Email** _____

Address _____ _____ (Apt.#/Ste.#)

_____ (City) _____ (State) _____ (Zip + 4)

Phone # (___) _____ (Business) _____ (Ext.) (___) _____ (Home) (___) _____ (Cell)

(*Co-Applicant refers to Spouse or Domestic Partners, Civil Union Partners, Same-Sex Partners, or other term specifically defined by any local, state or federal statute. Not applicable to Individual plans.)

(**Provide your email to receive member benefits. We do not sell your personal information to any third parties.)

Please indicate below, on a voluntary basis, if you are either blind or deaf. All information will be kept confidential, and used only to enhance the services provided by LegalShield.

○ **Blind** ○ **Deaf**

Associate Use Only

Associate # _____ **Bus. Phone** (___) _____ **Associate SSN** _____ (If Licensed)

Associate Name _____ (Last) _____ (First) _____ (MI)

Associate Lic. # _____ (In Florida) **Producer Identification Name/Number** _____

APP.PD (5.15)

Associate Signature X _____

2 Dependent Information

If you have more than five (5) dependents, please attach a separate piece of paper.

Name Last First MI **DOB** MM / DD / YYYY

Name Last First MI **DOB** MM / DD / YYYY

Name Last First MI **DOB** MM / DD / YYYY

Name Last First MI **DOB** MM / DD / YYYY

Name Last First MI **DOB** MM / DD / YYYY

In AL, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **In FL**, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **In NJ**, any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
In OR, any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information concerning a material fact may be subject to criminal or civil penalties and/or cancellation of the contract. **In TN**, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant: I agree the contract sets forth the terms of my membership. Such terms include any exclusions and limitations. I agree to be bound by the contract, and its terms and conditions, which will be provided to me by LegalShield, unless I cancel the contract, which I may do at any time by calling 1-800-654-7757. LegalShield may send the contract to me at my email address unless I communicate in writing that I do not agree to delivery by electronic means. If I have not listed an email address, or if required by a particular state, the contract will be sent by mail. My membership cards will be sent by mail. I may ask for a mailed copy of the contract at any time, or if I have not received my contract in 10 days from this application, I can request a copy by calling Member Services at 1-800-654-7757. The contract, with this application, is the entire agreement between LegalShield and me with respect to the membership and there are no agreements or representations other than as set forth herein and in the membership contract.

I acknowledge that I purchased this membership plan in the city of _____ in the state of _____.
By signing this application I confirm I am legally residing in the United States and agree to the below Payroll Deduction Authorization, the membership fees selected below, and the terms of the selected membership plan.

Employer _____ **Occupation** _____

Signature of Applicant X _____

3 Payroll Deduction Authorization

Today's Date MM / DD / YYYY

Applicant's SSN _____ For Internal Use Only

Applicant's Name Last First MI

I hereby authorize (Company Name) _____

City State **to deduct** $ ☐☐☐.☐☐

per (Circle one: week / month / other _____) from my earnings for my LegalShield, and subsidiaries membership and to remit such amount directly to LegalShield. I agree that the company will not be responsible or liable for my decision to purchase the LegalShield membership or the services provided through my membership and that company's sole responsibility is to withhold and pay my membership fee to LegalShield.

Signature of Applicant X _____