THE STAFFING EXCHANGE
AFFORDABLE HEALTHCARE FOR THE STAFFING INDUSTRY

Benefits Enrollment Worksheet

Your Personal Information

First Name:	Last Name:
SSN:	Home Phone:
E-mail:	Date of Birth:

Has any adult (19 and older) person to be insured used tobacco in the last 12 months?

☐ Yes ☐ No

Your Dependents' Information

Enter dependent information for all dependents who will be covered on your insurance plans.

Name	Relationship	Gender	SSN	Date of Birth	Disabled Y/N
	☐ Spouse ☐ Domestic Partner ☐ Child	☐ Female ☐ Male			
	☐ Child	☐ Female ☐ Male			
	☐ Child	☐ Female ☐ Male			
	☐ Child	☐ Female ☐ Male			

Your Beneficiaries

Enter primary and secondary (if applicable) beneficiary information for life insurance. The beneficiary percentage must equal 100%.

Primary Beneficiary

First Name	Last Name	Address	Relationship	Type (Primary or Secondary)	Beneficiary Percentage

Secondary Beneficiary (if applicable)

First Name	Last Name	Address	Relationship	Type (Primary or Secondary)	Beneficiary Percentage

****ALL PLAN OPTIONS ARE INDEPENDENT OF EACH OTHER****

Your Medical Plan Options

Select your medical plan from the following options. Check the box on the right based on the plan and coverage category. Check "waive" if you are waiving medical coverage.

Medical Plan(s)	Coverage Category	Your Weekly Contribution	Election
Medical Plan **MEC Basic** Preventive Care Services	Employee Only	$13.88	☐
	Employee + Spouse/DP	$34.82	☐
	Employee + Child(ren)	$31.36	☐
	Employee + Family	$51.78	☐
Medical Plan **MVP** No benefits will be paid until you have met your annual deductible $3000.00	Employee Only	$29.58	☐
	Employee + Spouse/DP	$281.71	☐
	Employee + Child(ren)	$279.90	☐
	Employee + Family	$482.16	☐
Waive Medical Coverage		$0.00	☐

Included with the MVP plan is TELADOC (a low-cost alternative for health care, giving members 24/7/365 access to doctors through their phone, mobile device, or computer)

MVP Plan Participants: $45 copay per televisit

Supplemental Plan	Coverage Category	Your Weekly Contribution	Election
Supplemental **TELADOC** *(a low-cost alternative for health care, giving members 24/7/365 access to doctors through their phone, mobile device, or computer)*	To be eligible, you must be enrolled in at least one voluntary plan: dental, vision, disability, etc.	$5.00 *(Note: Weekly contribution waived if enrolled in one of our medical plans.)*	☐
Waive Teladoc Coverage		$0.00	☐

Your Medical Indemnity Plan Options

It is NOT an ACA nor major medical insurance plan. An indemnity plan pays predetermined amount of money for any qualified medical services you receive. It can help you with the out-of-pocket costs that inevitably come with your medical insurance plan. Indemnity insurance provides limited benefits. It pays a certain amount per covered service up to a calendar-year maximum. It is **Post-Tax**.

Medical Indemnity Plan(s)	Coverage Category	Your Weekly Contribution	Election
Medical Indemnity Plan #1	Employee Only	$19.69	☐
	Employee + Spouse/DP	$46.00	☐
	Employee + Child(ren)	$32.38	☐
	Employee + Family	$51.78	☐
Medical Indemnity Plan #2	Employee Only	$28.15	☐
	Employee + Spouse/DP	$66.49	☐
	Employee + Child(ren)	$46.36	☐
	Employee + Family	$74.67	☐
Medical Indemnity Plan #3	Employee Only	$40.66	☐
	Employee + Spouse/DP	$96.77	☐
	Employee + Child(ren)	$67.30	☐
	Employee + Family	$108.71	☐
Waive Medical Coverage		$0.00	☐

Your Dental Plan Option

Check the box on the right based on the plan and coverage category. Check "waive" if you are waiving dental coverage.

Dental Plan	Coverage Category	Your Weekly Contribution	Election
Dental	Employee Only	$5.00	☐
	Employee + Spouse/DP	$9.71	☐
	Employee + Child(ren)	$10.03	☐
	Employee + Family	$14.30	☐
Waive Dental Coverage		$0.00	☐

Your Vision Plan Option

Check the box on the right based on the coverage category. Check "waive" if you are waiving vision coverage.

Vision Plan	Coverage Category	Your Weekly Contribution	Election
Vision	Employee Only	$1.38	☐
	Employee + Spouse/DP	$2.60	☐
	Employee + Child(ren)	$3.07	☐
	Employee + Family	$4.09	☐
Waive Vision Coverage		$0.00	☐

Voluntary Life

Check the box on the right based on the coverage category. Check "waive" if you are waiving voluntary life insurance.

Voluntary Life	Coverage Category	Your Weekly Contribution	Election
Voluntary Life	Employee Only	$1.06	☐
	Employee + Spouse/DP	$1.27	☐
	Employee + Child(ren)	$1.27	☐
	Employee + Family	$1.27	☐
Waive Vol Life Coverage		$0.00	☐

Voluntary Off-the-Job Accident

Check the box on the right based on the coverage category. Check "waive" if you are waiving voluntary accident insurance.

Accident Plan	Coverage Category	Your Weekly Contribution	Election
Off-the-Job Accident	Employee Only	$2.67	☐
	Employee + Spouse/DP	$4.84	☐
	Employee + Child(ren)	$5.15	☐
	Employee + Family	$7.14	☐
Waive Accident Coverage		$0.00	☐

Short-Term Disability (STD)

Check the appropriate box on the right if want to accept or waive short-term disability insurance.

STD Coverage	Your Weekly Contribution	Election
STD $650 Monthly Benefit	$3.92	☐
Waive STD Insurance	$0.00	☐

Voluntary Critical Illness

Check the box on the right based on the coverage category. See age-based rates below. Check "waive" if you are waiving critical illness insurance.

Critical Illness Plan	Coverage Category	Election
Critical Illness[1]	Employee Only	☐
	Employee + Spouse/DP	☐
	Employee + Child(ren)	☐
	Employee + Family	☐
Waive Critical Illness		☐

$10,000		
Issue Age	EE Only	EE + Dep
18-24	$1.80	$3.15
25-29	$2.20	$3.85
30-34	$3.30	$5.78
35-39	$5.50	$9.63
40-44	$8.80	$15.40
45-49	$13.20	$23.10
50-54	$19.20	$34.65
55+	$26.40	$46.20

[1] Critical Illness Insurance is unavailable to employees living in Indiana.

ELECTING COVERAGE:

I have reviewed the benefits offered and made my desired coverage selections (or waived coverage where applicable). I understand that the premiums for MEC and MVP elections will be administered on a pre-tax basis under Section 125 and that these elections are irrevocable until the next enrollment period or in the case of a Qualified Life Event. *Examples of a qualified life event include: childbirth, adoption, marriage, or loss of existing coverage.* The premiums for any supplemental elections will be administered on a post-tax basis.

_____ _____ _____

Employee Printed Name Employee Signature Date

WAIVING ALL PLAN COVERAGE:

I have reviewed the benefits offered and I am waiving ALL plan coverage until the next enrollment period or in the case of a Qualified Life Event. *Examples of a qualified life event include: childbirth, adoption, marriage, or loss of existing coverage.*

_____ _____ _____

Employee Printed Name Employee Signature Date

☐ If you are waiving coverage because you have existing coverage through another source, check this box and identify the source of your coverage (spouse, parent, Medicare, Medicaid, other employer, etc.) below:

Source of Coverage: _____

** You may change your elections, provided that you do so before the date on which your pre-tax deduction(s) under the plan(s) begins. To change your elections, you must complete a new Benefits Enrollment Worksheet.*
**Full-time employees will be eligible for the health plan following their waiting period (maximum of 90 days).*
** Davis Staffing will track and monitor employees' hours of service to determine eligibility for coverage in accordance with the Affordable Care Act.*
**If you have any questions about this Benefits Enrollment Worksheet, please contact Davis Staffing Human Resources at 708-747-6100.*
**You may obtain a copy of important notices and your Summary of Benefits and Coverage for your specific plan from our website* www.davis-staffing.com
**Each ID card mailed will include an additional copy of your Summary of Benefits and Coverage. You may also request a physical copy of the SBC if needed.*

ELECTION SNAPSHOT:

MEC ☐ $_____ DEN ☐ $_____ VIS ☐ $_____ SUP ☐ $____ ACC ☐ $_____ STD ☐ $_____ CRI ☐ $_____
MVP ☐ $_____
INDEMNITY 1 ☐ $_____
INDEMNITY 2 ☐ $_____
INDEMNITY 3 ☐ $_____

For internal completion. Sign and provide employee with a copy

Witness

I, _____ have reviewed with the above mentioned employee the selections made on this form.

_____ _____

Witness Signature Date