|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Gender: \_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |  |
| **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |
| **Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |
| **Date of Hire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |
| **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |
| **Spouse Name (if enrolling): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |
| **Spouse Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |
| **Spouse Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |
| **Spouse Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Child 1 Name (if enrolling): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Child Gender: \_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |  |
| **Child Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |
| **Child Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **\*If enrolling more than one child, please use next page to fill out required information** |  |
| ***Medical Plan with Harvard Pilgrim Health Care*** |   |   |   |   |   |   |
|  | **Elect Medical Insurance** |  |  |  | **Weekly Deduction** |  |
|  |  | I Elect Single Medical Coverage |  |  | $53.34 |  |  |
|  |  | I Elect Employee + Spouse Medical Coverage |  | $111.96 |  |  |
|  |  | I Elect Employee + Child(ren) Medical Coverage |  | $98.68 |  |  |
|  |  | I Elect Family Medical Coverage |  |  | $160.03 |  |  |
| **Employee Primary Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Spouse Primary Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Child 1 Primary Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ***Dental Plan with Northeast Delta Dental*** |   |   |   |   |   |   |   |
|  |  |  |  |  |  | **Select ONE Dental Plan** |
|  | **Elect Dental Insurance** |  |  |  | **High Plan Weekly** |  | **Low Plan Weekly** |
|  |  | I Elect Single Dental Coverage |  |  | $11.83 |  | $11.70 |
|  |  | I Elect Two Person Dental Coverage |  | $21.68 |  | $21.41 |
|  |  | I Elect Family Dental Coverage |  |  | $37.93 |  | $37.16 |
| ***Vison Plan with DeltaVision*** |   |   |   |   |   |   |   |
|  | **Elect Vision Insurance** |  |  |  |  | **Weekly Deduction** |  |
|  |  | I Elect Single Vision Coverage |  |  |  | $1.41 |  |  |
|  |  | I Elect Two Person Vision Coverage |  |  | $2.43 |  |  |
|  |  | I Elect Family Vision Coverage |  |  |  | $4.34 |  |  |

Receipt of June 1, 2022 Benefit Forms:

By signing below, I acknowledge that I have received the UHC Medical Plan Summary of Benefits & Coverage (SBC) electronically through the Employee Benefit Center. I know that if I want a hard copy of any of our benefit plan information or certificates, I can obtain one from Cheyanne Berard at colson@formupfoundations.com.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature

 Date

***Ryan Cronan, Employee Benefit Broker*** rcronan@therichardsgrp.com / 978-387-3346

***Cassie Crockett, Employee Benefit Broker*** ccrockett@therichardsgrp.com / 603-520-6874

