|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**](mailto:myspendingaccounts@mvphealthcare.com) | | | | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | | | | | | **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](mailto:colson@formupfoundations.com).

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

Employee Signature

Date

***Ryan Cronan, Employee Benefit Broker*** [rcronan@therichardsgrp.com](mailto:rcronan@therichardsgrp.com) / 978-387-3346

***Cassie Crockett, Employee Benefit Broker*** [ccrockett@therichardsgrp.com](mailto:ccrockett@therichardsgrp.com) / 603-520-6874

