

A Limited Benefit Plan

COBRA eligible after 4 consecutive weeks without payroll deductions or direct payments (Does not apply to Disability Income Coverage)

No coverage during periods without payroll deduction or direct payment to Benefits-In-A-Card

**FWM**

**Focus Workforce Management, Inc.**

This is not Major Medical Coverage

Return completed forms to: 855-899-5709 or

[faxing@benefitsinacard.com](mailto:faxing@benefitsinacard.com)

ENROLLMENT FORM

1-800-497-4856 \* M-F 8AM-9PM EST (Bilingual Agents on Staff)

# Coverage Elections

## Premiums displayed are weekly deductions

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Plan Options | Employee | | Employee  + Spouse | | Employee  + Children | | Family | |
| **Medical:** | | | | | | | | |
| Stay Healthy Plan/MEC *(ACA Compliant Plan)* |  | $15.34 |  | $18.39 |  | $18.86 |  | $21.54 |
| **VIP Plans –** May elect ONE with or without a Stay Healthy/MEC election | | | | | | | | |
| VIP Standard |  | $17.75 |  | $33.63 |  | $27.38 |  | $46.43 |
| VIP Classic |  | $19.66 |  | $38.15 |  | $30.33 |  | $52.33 |
| VIP Plus |  | $31.74 |  | $66.76 |  | $51.44 |  | $92.90 |
| **OR:** | | | | | | | | |
| MVP *(ACA Compliant Plan)* Failure to call and enroll in the MVP plan will be considered a declination | **Contact BIC to enroll: 1-800-497-4856** | | | | | | | |
| **Additional Benefit Options:** | | | | | | | | |
| Dental |  | $3.64 |  | $7.01 |  | $9.62 |  | $14.49 |
| Disability *(Must be working 20 hours or more to qualify)* |  | $3.95 | NA | | NA | | NA | |
| Life |  | $2.11 |  | $2.54 |  | $2.54 |  | $3.17 |
| Vision |  | $2.15 |  | $4.35 |  | $4.94 |  | $7.62 |
| Critical Illness |  | $2.51 |  | $3.87 |  | $2.78 |  | $4.13 |
| Accident |  | $2.01 |  | $2.95 |  | $3.01 |  | $4.54 |
| Behavioral Health |  | $1.50 |  | $1.50 |  | $1.50 |  | $1.50 |
| IDX Social Plus |  | $1.98 |  | $2.70 |  | $2.70 |  | $2.70 |
| **Coverages are effective on the Monday following your payroll deduction for benefits** | | | | | | | | |

|  |
| --- |
| For changes or cancellations, you MUST mark the appropriate box below and complete all required information. If no box is marked, this will be considered an enrollment form. **YOU WILL NOT BE CONTACTED**.  For faster results, call  **1-800-497-4856** |
| Change  Cancellation  |
| I understand that deductions will continue until request is processed. Premium will not be refunded. Changes coincide with premium adjustments. |

Are you covered by other Insurance?

Yes  No 

 **No Coverage: I choose not to participate**

# General Information Section Complete Entire Section (Please Print)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee’s Name | | Gender | Social Security Number | Country of Citizenship |  | Married |
|  | |  |  |  |  | Single |
| Home Address (Street or PO Box) | | City | | State | Zip Code | |
|  | |  | |  |  | |
| Date of Birth (MM/DD/YY) | Email Address | | | Telephone | | |
|  |  | | | ( ) | | |
| Beneficiary’s Full Name | | | | Relationship | | |
|  | | | |  | | |
|  | | | | | | |
| **Dependent Coverage Section (Please Use Additional Sheets if Necessary)** | | | | | | |
| Dependent’s Name | Relation | Gender | Social Security Number | Country of Citizenship | Date of Birth (MM/DD/YY) | |
|  | Spouse |  |  |  |  | |
|  | Child |  |  |  |  | |
|  | Child |  |  |  |  | |
| Signature: |  |  |  | Date: | | |

2022 Enrollment