**Employee Enrollee Information**

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| --- | --- | --- |
| **First Name** | **Last Name** | **Date of Birth** |
| **Social Security #** | **Phone #** | **Sex (Circle one)****Male or Female** |
| **Street Address** | **City/State** | **Zip Code** |

**Medical Coverage Election**

**You must select one option**.  *If you leave this section blank, you will be treated as having declined coverage. There are NO FEDERAL penalties or taxes for not having insurance coverage.*

 **I decline coverage for myself and all dependents.** (I wish to have no money deducted from my check)

I decline coverage due To: Existence of other coverage Medicare or Medicaid Other

 **I accept Minimum Essential Coverage (NOT Major Medical)**

This Minimum Essential Coverage (MEC) plan is NOT major medical and it does not provide for hospital coverage. Please see *Benefits Schedule* for a list of coverages and plan options. Premium is due one week in advance of coverage. The cost is approximately $16/week for employee coverage only. Prices are subject to change upon final pricing from insurance carrier. Please visit the Employee Resources and Health Insurance section of our website [www.dtcjobs.com](http://www.dtcjobs.com) for benefits schedule, application and coverage cost. \*\*If selecting this coverage, you must complete the additional application for the MEC (Benefits in a Card) Additional Application available in our office or on our website.

**Please select who you would like covered:**

Employee Only Employee + Spouse Employee + Children Employee + Family

**Please select the plan option:**

MEC VIP Standard VIP Classic VIP Plus

**Please select additional benefit options:**

 Disability Critical Illness Dental Vision  Life Accident  Behavioral Health IDX Social Plus

 **I accept coverage for Major Medical Plan (Provides Minimum Value)**

This plan is considered a Major Medical Plan. This plan meets Minimum Value (MV) and includes hospital coverage. For more information and plan details, please read the *Benefit Schedule* and *Health Insurance Memorandum* on the Employee Resources and Health Insurance section of our website at [www.dtcjobs.com](http://www.dtcjobs.com). The cost for this plan is approximately up to $534.97/mo. for employee only coverage based upon employee status (see *DTC Health Insurance Memorandum* for more info regarding employee status.). The cost is deducted one month in advance of coverage. Prices are subject to change upon final pricing from insurance carrier. \*\*If selecting this coverage, you must call *BIC at 1-800-497-4856 to enroll,* failure to call BIC to complete enrollment in the MVP Plan will be considered a declination.

Employee Only Coverage cost is approximately $534.97 per month

Employee plus Spouse is $1,093.47 per month

Employee plus child(ren) is $910.21 per month.

Family coverage is $1,470.73 per month

I hereby decline coverage or apply for participation in MEC and/or MV Benefit Plan for myself and/or my dependents as indicated above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by the plan Administrators for the plan I chose. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

**Employee (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**