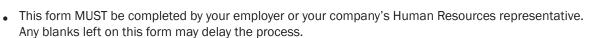
Case#: ____14207291___

Employer's Health Insurance Information





• If you have general questions about this form or the medical programs, please call 1-866-435-7414.



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A. GENERAL INFORMATION

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mation e: Solutions Staffing Group 750 Phone#: 801-223-7007 N 300 W, Suite 100, Provo, UT 84604 street apt.# city state zip ontact about employee health coverage at this job? Kali Tedford 223-7007 E-mail address: ktedford@esghr.com 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form. 2. Is your health insurance a state employee benefit plan? 3. Is the employee eligible to enroll in any insurance plan offered? If no, please explain:
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If no, please explain:
If yes, when is/was the employee eligible to enroll? (mm/dd/yy) 7/1/2019
4. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled:
5. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s):
If yes, name(s): If yes, when did coverage end/change? (mm/dd/yy)
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If yes, name(s) of person(s) enrolled:

^{*}An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

B. EMPLOYER'S LEAST EXPENSIVE PLAN

Questions below refer to the **employer's least expensive plan**.

- 1. Does the employee have to enroll in order to add their dependent(s)?
- 2. When will/did coverage begin? (mm/dd/yy) 7/1/2019
- 3. When does the company's next open enrollment begin? (mm/dd/yy) $\frac{03/01/2020}{}$
- 4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.



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Monthly Premium			
	Employee's Portion	Company's Portion	
Employee	\$ 63.96	\$ 484.24	
Employee + Spouse	\$ 134.16		
Employee + Child	\$ 194.12		
Family	\$ 198.12		

Yearly Health	Plan Deductible
Individual Amount	\$ 500
Family Amount	\$ 1000

C. EMPLOYEE'S HEALTH PLAN CHOICE

Questions below refer	to the plan that the	e employee has selected.	Questions 3-7	refer to	"in-network"	benefits
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1. Insurance company and plan name: SELECT HEALTH MED+ 500 TRAD
2. Policy number, if known:
3. Is the deductible \$2,500 or less per individual?
4. Is the lifetime maximum benefit \$1,000,000 or more?
5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
6. What benefits are covered under this plan? (Check all that apply.) ☑ Physician visits ☑ Hospital inpatient services ☑ Pharmacy/Rx
 7. Does the plan cover abortion services? If yes, under what circumstances: □ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape □ Other places describe:

8. Complete this chart only if it is different from the chart in Section B. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium			
	Employee's Portion	Company's Portion	
Employee	\$	\$	
Employee + Spouse	\$		
Employee + Child	\$		
Family	\$		

Yearly Health Plan Deductible		
Individual Amount	\$	
Family Amount	\$	

ĭ¥Yes □No	9. Are the employee's children currently enrolled or do they plan to enroll in your company's
	dental plan? If yes, name(s): Bethany and Magnolia Schow

D. SIGNATURE

I certify that I am a repr	resentative of the Human Resource Dep	Department, or that I am the health insurance contact person. If
	n is true and correct to the best of my k	y knowledge.
Signature: Michael	l Bramwell	Date: 6/10/2019
Name (please print): _	Michael Bramwell	

Title: HR Assistant Phone#: 801-223-7007