

D10819900460102

- This form **MUST** be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.
- A form must be completed for each employed household member. You may copy this form.
- If you have general questions about this form or the medical programs, please call 1-866-435-7414.

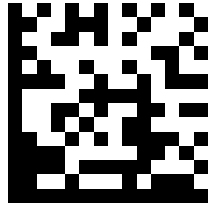
Employee Name: Brennon G. Schow Employee SSN#: 647-20-1352
(first, m.i., last)

Employer Name: <u>Solutions Staffing Group</u>				
EIN#: <u>30-0177750</u>		Phone#: <u>801-223-7007</u>		
Address: <u>4844 N 300 W, Suite 100, Provo, UT 84604</u>				
street		apt.#	city	state zip

B. EMPLOYER'S LEAST EXPENSIVE PLAN

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

- ☒ Yes ☐ No 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) 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 employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: SELECT HEALTH MED+ 500 TRAD
2. Policy number, if known: _____
- ☒ Yes ☐ No 3. Is the deductible \$2,500 or less per individual?
- ☒ Yes ☐ No 4. Is the lifetime maximum benefit \$1,000,000 or more?
- ☒ Yes ☐ No 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
- ☐ Yes ☒ No 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, please 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	\$

- ☒ 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 representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: Michael Bramwell Date: 6/10/2019

Name (please print): Michael Bramwell

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

Please return completed form to:
Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717