



Limited Benefits Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
 2. Elect or decline all benefits on the Enrollment Form.
 3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
 4. Return the Enrollment Form to your Branch Manager.
 5. Keep the Benefits at a Glance page for your records.
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This plan does not qualify as minimum essential coverage as defined under the Affordable Care Act (ACA). This plan is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

The Medical StaffCARE Fixed Indemnity Medical, Prescription Drugs, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204, 26.1801, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.
For questions or assistance, please call Medical StaffCARE Customer Service at 1-866-798-0803.

ENROLLMENT FORM MSC 4ESC P3D v18.2

A. REQUIRED EMPLOYEE INFORMATION			PRINT USING BLACK or BLUE INK (Must Be Filled Out)	
Name	Social Security #	Home Phone	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Address			Apt. #	
City	State	Zip	Date of Birth	/ /

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? ☐ Yes ☐ No. If Yes, please continue.






Medicare Health Insurance Claim Number (HICN) _____ Medicare Effective Date _____

Name of Covered Person (s):
 1. _____ 2. _____ 3. _____

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. This plan is underwritten by BCS Insurance Company.

	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only	<input type="checkbox"/> \$34.41 	\$5.40 	\$2.42 	\$0.60 	\$4.20 
Employee + Child(ren)	<input type="checkbox"/> \$57.12	\$14.58	\$6.54	\$0.90	
Employee + Spouse	<input type="checkbox"/> \$65.38	\$10.80	\$4.84	\$0.90	
Employee + Family	<input type="checkbox"/> \$87.06	\$20.52	\$9.20	\$1.80	
	<input type="checkbox"/> NO to ALL Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION				
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE **YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.


DATE ____/____/____ **SIGNATURE** _____

This is a Medical StaffCARE Enrollment Form.

LIMITED BENEFITS SUMMARY**FIXED INDEMNITY MEDICAL BENEFIT**

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits ¹

 Physician Office Visit	\$100 per day
Diagnostic (Lab)	\$75 per day
Diagnostic (X-Ray)	\$200 per day
Ambulance Services	\$300 per day
Physical, Speech, or Occupational Therapy	\$50 per day
Emergency Room Benefit - Sickness	\$200 per day
Emergency Room Benefit - Accident	\$1,000 per day
Outpatient Surgery	\$1,000 per day
Anesthesiology	\$400 per day
Annual Outpatient Maximum	\$2,250

Prescription Drugs ²

Annual Maximum	\$600
Per Day	\$30

Inpatient Benefits

Standard Care	\$700 per day
Intensive Care Unit Maximum ³	\$800 per day
Inpatient Surgery	\$4,000 per day
Anesthesiology	\$800 per day
Skilled Nursing ⁴	\$100 per day
First Hospital Admission (1 per year)	\$500
Annual Inpatient Maximum ⁵	No Limit

Accidental Loss of Life, Limb & Sight


Employee	\$20,000
Spouse	\$20,000
Dependent (6 months to 26 years)	\$5,000
Dependent (15 days to 6 months)	\$2,500

Wellness Care

Wellness Care (one per year)	\$100
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¹ all outpatient benefits are subject to the outpatient maximum ² not subject to outpatient maximum ³ pays in addition to standard care benefit ⁴ for stays in a skilled nursing facility after a hospital stay ⁵ Subject to internal limits of plan

DENTAL BENEFIT


 Coverage A	None / 80%
Coverage B	3 Months / 60%
Coverage C	12 Months / 50%

Waiting Period/Coinsurance

Annual Maximum Benefit \$750 **Deductible** \$50


Exams, Cleanings, Intraoral Films and Bitewings
Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Periodontics, Crowns, Bridges, Endodontics and Dentures

VISION BENEFIT ¹

	In-Network		Out-of-Network	
	You Pay	Plan Pays	You Pay	Plan Pays
 Eye Examination ² (including dilation)	\$10 Copay	100%	100%	\$35
Exam Options (Standard or Premium Contact Lens Fit)	Up to \$55 or 10% off Retail Price	\$0	100%	\$0
Frames ³	80%, after \$110 allowance	\$110, plus 20% of remaining	100%	\$55
Standard Plastic Lenses (single, bifocal, trifocal) ²	\$25 Copay	100%	100%	\$25-\$55
Lens Options	\$15-\$45 or 20% discount	100% or 20% off retail	100%	\$0
Contact Lenses (Conventional) ²	\$0 Copay, 85% of remaining	\$110, plus 15% of remaining	100%	\$88
Disposable Contact Lenses ²	\$0 Copay	\$110, plus balance	100%	\$88
Medically Necessary Contact Lenses ²	\$0 Copay	100%	\$0	\$200

¹ For complete plan details, please visit www.medicalstaffcare.com/vision ² Once every 12 months ³ Once every 24 months

TERM LIFE BENEFIT

 Employee Amount	\$10,000 (reduces to \$7,500 at 65; \$5,000 at 70)	Child Amount (6 mos to 26 yrs old)	\$5,000
Spouse Amount	\$5,000 (terminates at age 70)	Infant Amount (15 days to 6 mos)	\$1,000

SHORT-TERM DISABILITY BENEFIT

 Benefit Amount	60% of Salary up to \$150 per week
Waiting Period/Maximum Benefit Period	7 days, up to 26 weeks

WEEKLY LIMITED BENEFITS PREMIUM

	Medical	Dental	Vision	Term Life	STD
Employee Only	\$34.41	\$5.40	\$2.42	\$0.60	\$4.20
Employee + Child(ren)	\$57.12	\$14.58	\$6.54	\$0.90	-
Employee + Spouse	\$65.38	\$10.80	\$4.84	\$0.90	-
Employee + Family	\$87.06	\$20.52	\$9.20	\$1.80	-

LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

FIXED INDEMNITY MEDICAL AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law or
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

VISION

No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

TERM LIFE

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

Member Services:

For frequently asked questions and network information for the the Fixed Indemnity Medical Plan, please go to www.medicalstaffcare.com/FAQEC.

PLEASE NOTE: Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

Medical StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.paisc.com and click on "Members" and enter your group number.

