2011-2012 Enrollment Form

Plan Year from May 1, 2011 through April 30, 2012

ALL FULL TIME EMPLOYEES	Location:

Personal Information

Last Name	First Name	MI L	SSN	Gender M F	Marital Status SINGLE

Street Address

City	State	Zip code

Date of Birth	Date of Hire	Annual Salary	Effective Date

Medical – UnitedHealthcare

Medical Plan UHC 100/70 Coinsurance $3000 Deductible $30 OV Copay RX $15/$35$/$60	Pay Period Amount Employee Only ☐ $86.92 Employee & Spouse ☐ $249.94 Employee & Child(ren) ☐ $229.44 Employee & Family ☐ $395.30
Medical Coverage: Check all that apply	I waive medical coverage for ☐ Self; ☐ Spouse; ☐ Child(ren) Initial here to waive coverage: ________

Dental – UnitedHealthcare

Dental Plan UHC 100/80/50	Pay Period Amount Employee Only ☐ $13.82 Employee & Spouse ☐ $26.12 Employee & Child(ren) ☐ $26.95 Employee & Family ☐ $40.50
Dental Coverage: Check all that apply	I waive dental coverage for ☐ Self; ☐ Spouse; ☐ Child(ren) Initial here to waive coverage: ________

Vision - UnitedHealthcare

Vision Plan: UHC	Pay Period Amount Employee Only ☐ $2.11 Employee & Spouse ☐ $5.27 Employee & Child(ren) ☐ $5.05 Employee & Family ☐ $8.04

Vision Coverage: Check all that apply	I waive Vision coverage for ☐ Self; ☐ Spouse; ☐ Child(ren) Initial here to waive coverage: _________

Basic Life / AD&D Insurance

UHC Life / AD&D	☒ Basic Life/AD&D - Employer Paid $50,000 Life AD&D Benefit

Dependent Information

LIST YOUR DEPENDANTS FOR ANY PRODUCTS YOU ARE ENROLLING HERE

Dependent Full Name	Date of Birth (Children age 19-25 must be your tax dependent of full time student)	Gender (circle one)	Social Security Number	Student ?	Coverage
Spouse:	____/____/____	M / F	____-____-____	N/A	☐ Medical ☐ Dental ☐ Vision
Child 1:	____/____/____	M / F	____-____-____	Y / N	☐ Medical ☐ Dental ☐ Vision
Child 2:	____/____/____	M / F	____-____-____	Y / N	☐ Medical ☐ Dental ☐ Vision
Child 3:	____/____/____	M / F	____-____-____	Y / N	☐ Medical ☐ Dental ☐ Vision
Child 4:	____/____/____	M / F	____-____-____	Y / N	☐ Medical ☐ Dental ☐ Vision

ACKNOWLEDGEMENT OF PRE-TAX ELECTIONS

I authorize Angel Staffing, Inc. to deduct premiums from my payroll as indicated on this form. I understand that my elections will remain in effect for the entire plan year and cannot be revoked or changed unless I experience a qualifying event such as marriage, birth of a child, divorce or termination of my or my spouse's employment.

Pre-Tax Election

☐ YES – I authorize my employer to reduce my taxable salary in accordance with my election in any of the above benefits under the Flexible Cafeteria Plan

Post-Tax Election

☐ NO – I do not authorize my employer to reduce my taxable salary in accordance with my election in any of the above benefits under the Flexible Cafeteria Plan

Beneficiary Designation

(attach additional pages if needed)

Subject to the terms of the group policy, I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said policy. This Designation of Beneficiary refers only to a Group Life Insurance Policy.

Primary Beneficiary

Name	Social Security #	Date of Birth	Address	Relationship	Percentage
1.					
2.					

Contingent Beneficiary

Name	Social Security #	Date of Birth	Address	Relationship	Percentage
1.					
2.					

Employee - Printed name and Signature	Date