CONSTRUCTION RECRUITERS AMERICA STAFFING INC.®

GULFSHORE INSURANCE

2020 Medical Enrollment Form

Effective Date: _____

PERSONAL INFORMATION: *Please print clearly*

(Last Name) (First Name) (Middle Initial)

(DOB: MM/DD/YYYY) (Gender) (Social Security #) (Date of Hire: MM/DD/YYYY)

(Home Street Address)

(City) (State) (Zip) (Mobile/Home Phone #)

MEDICAL COVERAGE LEVEL AND PLAN INFORMATION

Select Plan: *Only choose one. Employee per **Weekly** Pay Period cost listed for each plan option.*

Florida Blue PPO Plan # 05903

☐ Employee $20.00	☐ EE & Spouse $160.53	☐ EE & Child(ren) $105.54	☐ Family $235.89

Florida Blue PPO Plan # 03768

☐ Employee $56.92	☐ EE & Spouse $248.40	☐ EE & Child(ren) $173.47	☐ Family $351.08

Waiver of Coverage: I understand that if I decide to apply later, coverage may not be available until the next open enrollment period or special event.

☐ **I refuse Medical coverage.**
☐ **I waive Medical coverage. I am covered under another health plan.** ***(enter information below)***

Heath Carrier Name: Policy/Contract #: Effective Date:

DENTAL COVERAGE LEVEL AND PLAN INFORMATION

Select Plan: *Only choose one. Employee **Weekly** Pay Period cost listed for each plan option.*

Metlife PPO Low Dental Plan

☐ Employee $7.08	☐ EE & Spouse $14.38	☐ EE & Child(ren) $16.35	☐ Family $25.37

Metlife PPO High (Buy-Up) Dental Plan

☐ Employee $8.62	☐ EE & Spouse $17.53	☐ EE & Child(ren) $18.86	☐ Family $29.66

DENTAL WAIVER *(only complete if waiving dental coverage)*

☐ **I waive this coverage.**

VOLUNTARY VISION COVERAGE LEVEL AND PLAN INFORMATION

Select Plan: *Only choose one. Employee per **Weekly** Pay Period cost listed for each plan option.*

Metlife Vision Plan

☐ Employee $1.97	☐ Employee & Spouse $3.95	☐ Employee & Child(ren) $3.35	☐ Family $5.52

VISION WAIVER *(only complete if waiving vision coverage)*

☐ **I waive this coverage.**

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DEPENDENT INFORMATION: *To be completed only if you are covering dependents for medical or dental benefits*
(If dependent information is not completed, employee will be enrolled in employee only coverage for the selected plan options)

Last Name, First Name, M.I.	Social Security:	Date of Birth:	Relation to You				Gender (M or F)	*If you choose "Other" please explain*
			Spouse (S)	Child (C)	Court Rppt. (A)	Other (o)		

***$25,000 EMPLOYER PAID BASIC TERM LIFE IS INCLUDED FOR ALL EMPLOYEE'S**

NAME YOUR LIFE AND AD&D INSURANCE BENEFICIARIES

	(First, Middle Initial, Last Name)	Relationship	SSN	DOB	Percent
Primary Beneficiary					%
Primary Beneficiary					%
				Primary beneficiaries must total 100%	
Contingent Beneficiary					%

REQUEST FOR SIGNATURE

I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing a payroll deduction from my earnings. I understand that if I decline or choose to enroll in any of the above coverages, I cannot later change my mind during the plan year and drop or change these coverages unless I experience a family status change (for example: marriage, divorce, birth or adoption of a child, death of a spouse or child) or a change in spouse's employment status.

REFUSAL OF COVERAGES

I understand that by declining any coverage, I cannot later change my mind during the plan year and elect these coverages unless I experience a family status change (for example: marriage, divorce, birth or adoption of a child, death of a spouse or child) or a change in spouse's employment status. If for any reason I fail to complete an insurance enrollment form for each plan year, the waivers shown on this form will remain unchanged. If for any reason I do not sign, complete and submit an insurance enrollment form before my enrollment date I will be considered waiving all coverages for the applicable plan year.

(Employee Signature) (Date)

* *CRAS offers a $5.00 weekly medical contribution discount to anyone who returns our proof of physical form, executed by a physician. This form can be returned at any point in time during your employment with CRAS and your discount will take effect on the first payroll cycle of the month following receipt. To request this form please email kam@crastaffing.com.*