Visit axiom.enroll1st.com to enroll in benefits.

AXIOM STAFFING GROUP, INC	ID#	Effective Date	Employee ID

PERSONAL INFORMATION

Member (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of Birth
Street Address and Apt #			
City, State	Zip Code	Home Phone	
Email Address		Date of Hire	

SPOUSE AND CHILD/DEPENDENT INFORMATION

Spouse (Last, First, M.I.)	Date of Marriage	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth

BENEFIT OPTIONS - Questions 1-3 pertain to Medical Benefits ONLY

1. Is anyone proposed for coverage covered by any Title XIIX program (e.g. Medicaid)?	☐ Yes ☐ No
If "Yes," please list name(s), who will be excluded from coverage:	
2. Are you actively at work on a full-time basis and able to perform the regular duties of your occupation?	☐ Yes ☐ No
If "No," you and your dependents are not eligible for coverage	
3. If applying for spouse and/or child(ren) coverage, is/are any of the proposed insured currently disabled?	☐ Yes ☐ No
If "Yes," list name(s), who will be excluded from coverage.	

DECLINE ALL COVERAGE. If you choose **not** to enroll in coverage, please sign below. I decline coverage at this time.

Signed in (City/State) _____ **Date** _____

Employee's signature_____

PREMIUMS	MINIMUM ESSENTIAL COVERAGE	HOSPITAL INDEMNITY	STOP DENTAL STOP You cannot enroll in dental coverage without enrolling in the Hospital Indemnity Coverage
Employee Only	☐ $48.15 monthly	☐ $19.37 weekly	☐ $4.85 weekly
Employee + Spouse	☐ $71.00 monthly	☐ $38.17 weekly	☐ $9.44 weekly
Employee + Child(ren)	☐ $91.77 monthly	☐ $30.86 weekly	☐ $10.25 weekly
Family	☐ $122.81 monthly	☐ $45.65 weekly	☐ $15.84 weekly

GROUP TERM LIFE ☐ $15,000 Benefit Level ☐ $20,000 Benefit Level

TOBACCO: Y N AGE: _____ Salary: _____

Spouse's Signature (if applicable) _____

EMPLOYEE'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled, on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administration office. Lastly, I understand that completion of this enrollment form in no way implies that I will be accepted for coverage.

Signed in (City/State) _____ Date_____

Employee's signature_____

I agree that typing my full legal name and last four digits of my social security number shall be the electronic representation of my signature for all purposes, with the exception of the cancellation of any coverage, when I {or my Agent} use them on documents, including legally binding contracts, to include all Employee Benefits applications and Section 125 forms, just the same as a pen and paper signature.

Full Legal Name _____ Last Four Digits of Social _____

Licensed Representative's Name _____ Licensed Representative's Signature _____Agent #_____

If you did not enroll online please complete all fields on the enrollment form and fax it to 877 456 4787

If all fields are not completed your enrollment will not be processed.