2018 HEALTH BENEFIT OVERVIEW

MEC (MINIMUM ESSENTIAL COVERAGE)

This coverage meets the requirement of the Affordable Care Act. By purchasing this MEC plan, you will be exempt from the tax levy under the Individual Mandate.

All services on this plan are 100% covered when received in MultiPlan network. This plan provides no coverage for sickness/hospitalization/surgical benefits.

MONTHLY PREMIUMS			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$53.43	$77.11	$97.95	$128.63

TELADOC

This benefit is included with your MEC.
Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.
GET THE CARE YOU NEED: Teladoc doctors can treat many medical conditions, including:
Cold & flu symptoms, Allergies, Bronchitis, Skin problems, Respiratory infection, And more!

HOSPITAL INDEMNITY INSURANCE

This coverage does not qualify for exemption under the Individual Mandate of the Affordable Care Act.
The HIP Plan:
- No Deductible Before Your Benefits Kick In!
- Offers benefits for sickness, pharmacy, and hospitalization
- No Pre-existing Condition Restrictions

WEEKLY PREMIUMS			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$19.37	$38.17	$30.86	$45.65

DENTAL INSURANCE

You must be enrolled in Hospital Indemnity to purchase dental insurance.

For as little as $4.85 per week, participants receive comprehensive coverage to control out-of-pocket expenses.--Max of $1,000

WEEKLY PREMIUMS			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$4.85	$9.44	$10.25	$15.84

LIFE INSURANCE

There is no way to know what will happen tomorrow. Prudent financial planning can help protect you and your family's future, offering peace of mind.
- Guaranteed Acceptance up to $15,000
- Individual or family coverage available

SAMPLE WEEKLY PREMIUMS FOR $20,000 IN COVERAGE* (Non-smoker)					
Age 25	Age 30	Age 35	Age 40	Age 45	Age 50
$1.40	$1.60	$1.95	$2.67	$3.58	$4.73

To request a full brochure of benefits email kdunn@firststaffbenefits.com

CALL US TOLL-FREE: 866-629-5456

COMPLETE ENROLLMENT ONLINE @ AXIOM.ENROLL1ST.COM

Please complete this enrollment form and fax it to 877 456 4787

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

Name	Student Status	Gender	Social Security No.	Date of Birth
Spouse (Last, First, M.I.)		☐ 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

Question	Answer
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	DENTAL You must enroll in the hospital indemnity policy to purchase this coverage.
Employee Only	☐ $53.43 monthly	☐ $19.37 weekly	☐ $4.85 weekly
Employee + Spouse	☐ $77.11 monthly	☐ $38.17 weekly	☐ $9.44 weekly
Employee + Child(ren)	☐ $97.95 monthly	☐ $30.86 weekly	☐ $10.25 weekly
Family	☐ $128.63 monthly	☐ $45.65 weekly	☐ $15.84 weekly

GROUP TERM LIFE ☐ I would like to enroll in this coverage. (Note: You must call 866-629-5456 to receive your applicable rate.)

TOBACCO: Y N AGE: _______

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 #__________