SEIU Local 32 BJ, District 36 BOLR Welfare Fund
36 Phlex Plan Enrollment Worksheet/Form

Participant Last Name	First	Middle Initial	Social Security #

Participant Address:	Street	Apt#	City	State	Zip Code

Date of Birth:	Sex:	Marital Status:

Your 36 Phlex Plan Options

Fold here---- **Each option is shown below. After reading your Benefits Guide, choose the plan in which you want to enroll and level of coverage.** Circle your choice. **Complete all information on this form. Be sure to sign and date the form and return to the Fund Office in the envelope provided. If you are newly eligible or have changes in your dependent status, you must complete a Census Card/Beneficiary card. Contact the Fund Office if you need a new Census card. Circle each of your benefit choices and write the number that appears under your selection in the column to the right (*Phlex*Points Used).** ----Fold here

PLEASE NOTE: YOU MAY ONLY CHOOSE ONE SELECTION FROM EACH BENEFIT AND ONLY ONE COVERAGE LEVEL FOR EACH BENEFIT SELECTED.

Benefit	Coverage Level: Employee Only	Employee + 1	Family	*Phlex*Points Used
1. Medical (includes Prescription Drug Benefits)				
High Option Plan	90	90	90	
Basic Plan	85	81	78	
Opt-Out: If you choose this option, complete the Proof Of Other Coverage form and return with this enrollment form	50	50	50	
2. Dental				
Dental Preferred Provider Plan (PPO)	7	7	7	
Opt-out	0	0	0	
Fold here-- **3. Vision** --Fold here				
Enhanced Vision Plan	2	2	2	
Discount Vision Program	1	1	1	
4. Life Insurance				
$10,000	0			
$25,000	1			
$50,000	3			
5. Total *Phlex*Points Used: (Add up the points used in items 1 through 4 above.)				

If your *Phlex*Point total (Line 5 above) is greater than 100, you must make a monthly contribution towards the cost of your benefits. Use the formula below to calculate the amount of your monthly contribution.

Line 5 Total	Minus 100	Times $5	Equals	Your Monthly Payroll Deduction For Benefits
	- 100	X $5	=	$

If the number of points in line 5 is less than 100, you have *Phlex*Points that you may deposit in one or both of the Reimbursement Accounts. For Benefit Year 2012, each *Phlex*Point is worth $5.

Fold here-- **6. Reimbursement Accounts** --Fold here

	Number of *Phlex*Points to contribute	Amount (*Phlex*Points times $5)
Health Care Reimbursement Account		
Dependent Care Reimbursement Account		

Authorization—Important!

My signature below indicates that I have read and understood this enrollment form and the descriptive materials made available to me by the SEIU Local 32BJ, District 36 BOLR Welfare Fund. I request to arrange for the above coverage and direct my employer to deduct any required contributions from my pay. I understand that these elections will remain in effect until the next annual enrollment period unless I have a qualified change in family status. I certify that the information on this form is complete and accurate to the best of my knowledge. I understand that if this information changes in the future, I am obligated to notify the Fund Office within 31 days. Failure to do so may affect benefit coverage.

Participant Signature **(PLEASE SIGN YOUR NAME HERE)** Date Signed