



**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 |
| Date of Birth: | | Sex: | Marital Status: | Zip Code | |

Your 36 Phlex Plan Options

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 (*PhlexPoints Used*).

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

| Benefit | Coverage Level | | | PhlexPoints Used |
|---|----------------|--------------|--------|------------------|
| | Employee Only | Employee + 1 | Family | |
| 1. Medical (Includes Prescription Drug Benefits) | | | | |
| High Option Plan | 94 | 117 | 141 | |
| Basic Plan | 89 | 107 | 126 | |
| Opt-Out: If you choose this option, complete the Proof Of Other Coverage form and return with this enrollment form | 60 | 60 | 60 | |
| 2. Dental | | | | |
| Dental Preferred Provider Plan (PPO) | 4 | 6 | 7 | |
| Opt-out | 0 | 0 | 0 | |
| 3. Vision | | | | |
| Enhanced Vision Plan | 1 | 2 | 2 | |
| Discount Vision Program | 0 | 0 | 0 | |
| 4. Life Insurance | | | | |
| \$10,000 | 0 | | | |
| \$25,000 | 1 | | | |
| \$50,000 | 3 | | | |
| 5. Total PhlexPoints Used: (Add up the points used in items 1 through 4 above.) | | | | |

If your *PhlexPoint* 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 *PhlexPoints* that you may deposit in one or both of the Reimbursement Accounts. For Benefit Year 2012, each *PhlexPoint* is worth \$5.

6. Reimbursement Accounts

| | Number of PhlexPoints to contribute | Amount (<i>PhlexPoints</i> 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

