ENROLLMENT APPLICATION

(Email Completed Forms to wortiz@jfcglobal.com)

SBMA

EMPLOYEE INFORMATION

Name_____ Social Security Number_____

Employer_____ Hire Date_____

Birth Date_____ Sex ☐ Male ☐ Female

Address_____ Phone Number_____

City/State/Zip_____ Email_____

DEPENDENT INFORMATION

Name_____ Name_____

Social Security Number_____ Social Security Number_____

Birth Date_____ Birth Date_____

☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Male ☐ Female ☐ Spouse ☐ Child

Name_____ Name_____

Social Security Number_____ Social Security Number_____

Birth Date_____ Birth Date_____

☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Male ☐ Female ☐ Spouse ☐ Child

COVERAGE ELECTIONS

Medical Election (choose only 1)				
Weekly Rates	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
EnhancedCare	☐ $21.23	☐ $41.53	☐ $42.74	☐ $62.11
EliteCare	☐ $44.22	☐ $95.76	☐ $97.82	☐ $144.18
MV Zero*	☐ $93.72	☐ $191.76	☐ $167.07	☐ $268.99
*Rates for the MV plan are subject to change based on affordability. Please contact your employer for specific rates.				

Ancillary Election				
Weekly Rates	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
ExtraCare	☐ $11.31	☐ $22.62	☐ $22.62	☐ $33.92

☐ waive coverage

EMPLOYEE ACKNOWLEDGMENT

I hereby acknowledge the offer of health insurance coverage, providing Minimum Essential Coverage (MEC) and Minimum Value (MV), for myself, and my eligible dependents. If electing coverage, I authorize my employer to make salary reductions for my portion of the insurance premiums. I understand that I may not make changes to my coverage elections until my employer's next open enrollment period or due to a qualifying event.

Signature_____ Date_____