Enrollment Form for Group Insurance

AXIS Global Accident and Health Insurance

ternian

Step 1: Select Your Enrollment Method (Choose one only.)

1. WEB: http://paycheckconnection.myternian.com **2. PAPER:** Turn in the form to your employer

YOUR GROUP NUMBER IS: **8999858**

Search PHCS network providers at: www.myternian.com or call 1-866-750-7427
(You DO NOT need to use these providers – they provide discounts should you choose to visit them. You can visit ANY licensed physician and present your insurance card – you may qualify for a discount. But regardless, you still have insurance coverage as outlined in this brochure.)

Step 2: Select the plan(s) that you want. DETAILS AND PRICING FOR EACH PLAN ON PREVIOUS PAGES.

Group Term Life
❑ $10,000Plan
❑ $20,000 Plan

❑ EE Only
❑ EE + Dependent
❑ EE + Family

Step 3: Select who you want to cover. CHECK ONLY ONE EVEN IF MULTIPLE PLANS ABOVE ARE SELECTED.

❑ I want to cover myself only ❑ I want to cover myself and 1 dependent (spouse or child) ❑ I want to cover myself and my family

Step 4: Provide the information that we need in order to enroll you and/or your family members.

First Name M.I. Last Name Gender (M/F) Date of Birth

Social Security Number Hire Date

Street Address City State Zip Code

Email Address (REQUIRED for DoctorNavigator login access) Primary Phone # ☐ Home ☐ Work ☐ Cell

DEPENDENT INFORMATION (IF ANY): For more than 3 dependents attach additional sheet.

Spouse/Child	First Name	M.I.	Last Name	Gender (M/F)	Full Time Student? ☐ Yes ☐ No	Birth Date (mm/dd/yyyy)
					Full Time Student? ☐ Yes ☐ No	
					Full Time Student? ☐ Yes ☐ No	

BENEFICIARY INFORMATION: Person who will receive benefits in the case of your death. You will be the beneficiary for dependents.

First Name M.I. Last Name Gender (M/F) Relationship to You

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Employee's Signature Date Signed

Declination Waiver: (check the box below if you are not enrolling in the plan; YOU ARE STILL REQUIRED TO SIGN AND DATE THE FORM):

☐ I choose not to enroll in the plans being offered by my employer. I understand that, if at a later date, I wish to enroll in this plan, I will not be able to do so until there is another open enrollment period.

I have read the AXIS Global Accident and Health Insurance Company enrollment brochure, including the exclusions and limitations, and accept the terms and conditions of the coverages outlined in it. I understand the fixed indemnity insurance plans are not considered creditable coverage under HIPAA and do not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment brochure and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the brochure only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I authorize my employer to deduct the required premium for the plan I have elected from my pay. If direct billing is offered, I authorize Ternian Insurance Group to charge the required premium for the plan I have elected from my credit or debit card. To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclose information about me.

TeleMedicine Through HealthiestYou

24x7 Access to Doctors

When you get sick, our doctors are standing by 24x7 waiting to help you. They can diagnose, treat, and often prescribe for an array of medical issues.

Provider Discovery

Need to search for a nearby doctor, dentist, or other provider? Our radar makes it easy. You can even research your doctor first!

Prescription Savings

Our awesome price comparison engine can save you up to 85% by shopping and comparing a variety of prescriptions to find the best prices nearby.

HealthiestYou is changing the way real people access healthcare!
For only $19.95/month.

☐ **Employee Only**		☐ **Employee + Family**	
Name	**Relationship**	**Gender**	**Date of Birth**
	Employee		
Address:			
City, State, Zip:		Phone:	
Email Address:			

_____
Signature

PayCheck Connection
To Support Your Business Needs

Phone: 877.303.7590 Fax: 877.303.7591
PO Box 1510; Hayden, ID 83838

VSP Vision Plan Enrollment/Change Form

GROUP INSURANCE

Vision care for life

For Sambedino, Inc. Use Only	
Date Sent to Payroll Dept.: _____ by: _____ Date Sent to Benefits Dept.: _____ by: _____ Date Added to VSP Spreadsheet _____ by: _____	Employee Effective Date: _____

SECTION 1: QUALIFYING EVENT (Please Check One)

☐ New Hire ☐ Open Enrollment ☐ Plan Change

☐ Add/Delete Dependents (Indicate below date of qualifying event. Then complete entire form)

Marriage: ____/____/_____ New Birth: ____/____/_____ Divorce: ____/____/_____ Adoption: ____/____/_____ Other:_____

☐ Address/Name Change/Correction ☐ COBRA Continuation ☐ Do Not Want Coverage – Waive

☐ Termination Date Effective: ____/____/_____

Reason: ☐ Left Employment ☐ Reduced Hours ☐ Waived Coverage ☐ Other Insurance

SECTION 2: MEMBER INFORMATION

Social Security Number	Date of Birth	Marital Status ❒ Single ❒ Married	# of Dependents Including Spouse	Gender ❒ Male ❒ Female

Member's Last Name First M.I.

Home Address (P.O. Box not acceptable unless rural P.O. Box)	City	State	Zip Code

Client Name	Position/Title/Job Classification	Home Phone	**Date of Hire (Required)**

SECTION 3: DEPENDENT INFORMATION

Add	Change	Delete	Last Name (if different), First, MI	Social Security #	Relationship to member	M/F	Date of Birth
			(Spouse)				
			(Child)*				
			(Child)*				
			(Child)*				
			(Child)*				

* If dependent is age 19 to 24 and is a full-time student, the following documentation must be provided to VPS at time of application: class schedule or letter from registrar's office with name of institution, student's name, number of credit hours, and semester/quarterly period.

SECTION 4: OTHER INSURANCE COVERAGE

Do you or your spouse have coverage under another group vision insurance plan? ❒ YES – Please complete this section. ❒ NO – Please skip to Section 5.

Insurance Co. Name	Insurance Co. Phone Number:
Name of Policy Holder	Policy Holder's S.S. #:

Employee Name	Policy Holder's Date of Birth:	Effective Date of Coverage:

SECTION 5: AUTHORIZATION

I hereby apply for membership with the VSP Vision Plan and authorize my employer/union/group policy holder to deduct from my earnings the necessary contribution, if any is required of me. I hereby authorize any physician, dentist, hospital, or insurer having any records or information concerning health history or other insurance for me, or my minor dependents, to furnish such records, data, or information as may be requested by VPS or their duly authorized representative to review eligibility, determine benefits (if any) and/or process vision claims. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I, or any authorized representative may receive upon request, a copy of this authorization

It is the member's responsibility to notify Sambedino, Inc. of any changes of address or family status in writing by completing a new form.

❒ I do not want to participate in the VSP vision program. I am waiving coverage. (Please check the box and sign below.)

Employee/Member Signature	Date Signed	Employer Signature	Company Name

LIFE FLIGHT NETWORK

There. When You Need Us.®

GROUP MEMBERSHIP ENROLLMENT

PayCheck Connection, LLC

MEMBER ENROLLMENT INFORMATION

Name: _____ Date of Birth: _____

Spouse/Domestic Partner: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Additional Eligible Household Members:

Includes any dependents claimed on your tax return and elderly or disabled family members living in the same household

	Date of Birth	Relationship

_____ I am an existing member. ID# (if known)_____

Member's Signature: _____

GROUP DISCOUNT MEMBERSHIP:

- Annual fee of $75 per year per household.
- Discount rate is valid with enrollment through an approved group only.
- Payment directly to Life Flight Network is not available.
- Complete Statement of Understanding is found on the reverse side of this form.

LIFE FLIGHT NETWORK FOUNDATION
P.O. Box 3841 • Portland, Oregon 97208-3841
Phone: (503) 678-4370

This form is valid through 11/30/2020. Contact your employer or group representative for an updated enrollment form if this form is expired. New member benefits take effect 72 hours after receipt of completed enrollment form and payment. Life Flight Network transports patients based on medical need, not membership status. Medicaid beneficiaries should not apply for membership. Life Flight Network operates under its own FAA Part 135 Air Carrier Certificate.

STATEMENT OF UNDERSTANDING

By becoming a Life Flight Network Member, you agree to the terms stated below.

A Life Flight Network Membership relieves you from liability for out-of-pocket costs of emergent, medically necessary transports completed and billed by Life Flight Network. Your membership is not an insurance policy but secondary to insurance carriers and health care cost sharing programs. All available insurances will be billed first including health, auto, workers compensation and third-party insurance. Life Flight Network will accept payment from insurance carriers and other third party payers as payment in full.

Membership benefits are available for those eligible household members listed on the member record at the time of transport if the transport is an emergent, medically necessary transport to the closest, most appropriate facility, performed by Life Flight Network, its contracted agents, or reciprocal partners, subject to the reciprocal program's rules.

Membership benefits are extended to the primary member, his/her spouse or domestic partner and dependents claimed on their income tax return. Dependents must be added to the member record within 30 days of birth or adoption. Elderly (age 65+) and disabled family members living in the same household are also covered. Life Flight Network may require documentation or other verification of membership eligibility.

Emergency medical transports are based on medical need, not membership status. Medical need can only be determined by a physician, EMS provider, hospital or another qualified third-party recognized by Medicare, and is in all cases subject to the final determination of the health insurance carrier, if any. Non-emergent transports are not eligible for Life Flight Network membership benefits.

Availability of service cannot be guaranteed due to weather conditions, maintenance, commitment to another transport, out-of-service equipment and other reasons.

New and lapsed membership benefits take effect 72 hours after receipt of a completed enrollment with payment.

Membership fees are non-refundable, non-transferable and are not tax-deductible. Life Flight Network may cease selling and servicing memberships should any governmental body, now or in the future, determine memberships can no longer be offered within their jurisdiction. No refunds will be made for any memberships already purchased.

I transfer directly to Life Flight Network my rights to insurance payments due to me for services provided by Life Flight Network. Such payments shall not exceed Life Flight Network's regular charges. Denial of a claim by an insurance provider must be received by Life Flight Network in writing. Membership benefits do not extend to transports deemed not medically necessary or when insurers deny payments due to coordination of benefit issues. Per government regulations, individuals covered by Medicaid are not eligible for Life Flight Network membership and should not apply.

I specifically release and waive any and all rights, claims or causes of action against Life Flight Network and its employees and agents with respect to my Life Flight Network Membership.

The Membership Program may be canceled at any time for any reason, including financial feasibility and governmental regulation of such programs. Terms and conditions are subject to change. For current terms see www.lifeflight.org

PATIENT AGREEMENT AND DISCLOSURE STATEMENT

Heritage Health

- I acknowledge and understand that I am voluntarily becoming a patient of Heritage Health Community Health Center and that this agreement is non-transferable.
- I have reviewed the EVERYDAY***Wellness*** Patient Services Guide and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance.
- I understand that this plan only provides the health care services described in the EVERYDAY Wellness Patient Services Guide.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of this plan including, but not limited to emergency room, hospital and specialty services and that Heritage Health CHC will not bill insurance carriers for services provided to me while on this plan.
- I acknowledge and understand that Heritage Health CHC must maintain a record of my health information.
- I acknowledge and agree to pay my monthly care fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged late fees and that my service agreement may be terminated.
- I acknowledge and understand that Heritage Health CHC may terminate this agreement by providing me 10 days written notice and any prepaid care fees will be prorated to the date of termination and refunded to me within (10) ten business days. Heritage Health CHC will not terminate this agreement solely on the basis of health status.
- I acknowledge and understand that Heritage Health CHC may add or discontinue services or may increase my fee schedule at any time, and that I will be given in writing, at least sixty (60) days notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the Medicare Opt-Out Agreement for review and signature before my first appointment.
- I agree that neither myself nor Heritage Health CHC will seek reimbursement for the care that I receive from a third party insurance program.

My signature below indicates that I have read, reviewed and understand the terms and conditions of my membership program with Heritage Health Community Health Center

Print Name: _____

Signature: _____ **Date:** _____

Emp Last Name:	First Name:	MI:	Date of Birth:	☐ M ☐ F
Social Security Number:	Are you enrolling yourself? ☐ Yes ☐ No		Dependants ☐ Yes ☐ No	
Home Address:	City:		State:	Zip:
Billing Address:	City:		State:	Zip:
Phone #1: ( )	☐ Home ☐ Work ☐ Cell	Phone #2: ( )	☐ Home ☐ Work ☐ Cell	
Email Address:			Allow Emails? ☐ Yes ☐ No	
Employer through which you obtain your EDW account:	**PayCheck Connection LLC Payroll Services Group**			
Emergency Contact:	Phone: ( )		Relationship:	
Enrollee Name:	Date of Birth:		Social Security #:	
Spouse Name:	Date of Birth:		Social Security #:	
Dependent Name:	Date of Birth:		Social Security #:	
Dependent Name:	Date of Birth:		Social Security #:	
Dependent Name:	Date of Birth:		Social Security #:	
Dependent Name:	Date of Birth:		Social Security #:	
Dependent Name:	Date of Birth:		Social Security #:	

LegalShield® Worry Less. Live More.

IDentityTheft SHIELD

Corporate Offices: One Pre-Paid Way • Ada, OK 74820
www.LegalShield.com • 800-654-7757
LegalShield is the trade name of Pre-Paid Legal Services, Inc. and its sub idiaries.

OFFICE USE ONLY			
CWA		PLAN	
FOB		FRAN	
MODE		GR#	

Select Applicable Sub idiary:

- ☑ Pre-Paid Legal Services, Inc.
- ○ Pre-Paid Legal Casualty, Inc.
- ○ Legal Service Plans of Virginia, Inc.
- ○ Pre-Paid Legal Services, Inc. of Florida
- ○ Pre-Paid Legal Access, Inc.

P OY B N IT M B RS IP APP ICATION ○ MAS

Toda 's Da e ___/___/_____ MM DD YYYY

Time of Da ——— ○ A.M. ○ P.M.

Plea e Choo e the appropriate plan:

- ☑ Standard Plan
- ○ Additional Trial Defen e
- ○ IDT ST___ GOLD___ MINORS___
- ○ Other _____

A $10 non-refundable fee ($25 for CDLP) is waived due to your emplo er offering this at work.
Plea_e prin_ LEGIBLY in ALL CAPITAL le_ers, u_ing ONLY BLUE or BLACK INK.

❶ Per onal Informa ion

The informa ion you pro ide on this applica ion is con idered non-public informa ion, and LegalShield take care to pro ect your informa ion.

○ Mr. ○ Mrs. ○ Mis . ○ Ms. ○ Dr.

Applican 's SSN _____ For In ernal U e Only

DOB ___/___/_____ MM DD YYYY

Applican 's Name _____ La _____ Fir t _____ MI

***Co-Applican 's Name** _____ La t _____ Fir t _____ MI

(*Co-Applicant refers to Spou e or Dome ic Partners, Civil Union Partners, Same-Se Partners, or o her term specifically defined by an local, sta e or federal s a u e.)

Address _____ Apt.#/Ste#

_____ Cit _____ Sta e _____ ip

Phone # ( ) _____ Bu ine ( ) _____ E t. ( ) _____ ome ( ) _____ Cell

Email _____ (Your privac is a priorit with us We ill not sell your email addre s or personal informa ion of an kind to third part vendors.)

Plea e indica e belo , on a volun ary ba is, if you are either blind or deaf. All informa ion will be kept confiden- ial, and u ed only to enhance the services pro ided by LegalShield to its blind and/or deaf a ocia es and members.

○ **Blind** ○ **Deaf**

A ocia e U e Only

A igned A ocia e Number 114613185 Bu ine phone (208) 762-7590

A ocia e Name Schultz, Carolyn Last _____ Fir t _____ MI

A ocia e SSN Number _____ (If Licen ed) A ocia e Lic. Number _____ (In Florida)

A ocia e Signa ure X C. Schultz

APP.PD (10.12)

2 Dependent Information

If you have more than five (5) dependents, please attach a separate piece of paper.

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

Name _____ (Last) _____ (First) ____ (MI) **DOB** ____/____/_____ (MM/DD/YYYY)

In AL, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who **knowingly presents false information in an application for insurance is guilty of a crime and may be sub ect to** restitution fines or confinement in prison, or any combination thereof. **In FL, any person who knowingly and** with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any **false, incomplete, or misleading information is guilty of a felony of the third degree. In NJ, any person who includes any false or misleading information on an application for an insurance policy is sub ect to criminal and civil penalties. In OR**, any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files **a statement of claim or an application containing any false, incomplete, or misleading information concerning a material fact may be sub ect to criminal or civil penalties and/or cancellation of the contract. In TN, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of** defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant: I understand that the written contract sets forth the terms of my membership, including any e clusions or limitations, and agree to be bound by the same. I further understand that the company will mail the written contract to me at the address noted herein within the ne t fourteen days. If I have not received my contract within that time frame, I understand that it is my responsibility to call LegalShield to obtain a copy. The written contract, together with this application, constitutes the entire agreement between the company and the member with respect to the membership, and there are no agreements, understandings, or representations other than as set forth herein and in the membership contract.

I hereby acknowledge that on this date, I purchased this plan in the city of in the state of . By signing this application I certify I am legally residing in the United States and agree to the above Authorization of Payment and membership fees selected above.

Employer _____ **Occupation** _____

Signature of Applicant X _____

3 Payroll Deduction Authorization

Today's Date ____/____/_____ (MM/DD/YYYY) **Applicant's SSN** _____ (For Internal Use Only)

Applicant's Name _____ (Last) _____ (First) ____ (MI)

I hereby authorize (Company Name) PayCheck Connection, LLC

_____ (City) _____ (State) **to deduct** $ ____.__

per (Circle one: week / month / other _____) from my earnings for my LegalShield, and subsidiaries membership and to remit such amount directly to LegalShield. I agree that the company will not be responsible or liable for my decision to purchase the LegalShield membership or the services provided through my membership and that company's sole responsibility is to withhold and pay my membership fee to LegalShield.

Signature of Applicant X _____