LSI

Benefits-In-A-Card

A Limited Medical, Mini-Medical Plan
This is not Major Medical Coverage
1-800-497-4856
www.benefitsinacard.com
Enrollment Form
Please Complete Entire Section (Print)

No coverage during periods without payroll deduction or direct payment to Benefits-In-A-Card.

COBRA eligible after 4 consecutive weeks without payroll deductions or direct payments.

YES	Select One
❑	Employee
❑	Employee + One
❑	Family
NO ❑	No Coverage

Select Basic Coverage and Desired Options	
Medical	❑
Hospital Indemnity	❑
Dental	❑
Disability	❑
Term Life	❑
Vision	❑
Accident	❑
Critical Illness	❑

For changes or cancellations, you **MUST** mark the appropriate box below and complete all required information. If no box is marked, this will be considered an enrollment form. **YOU WILL NOT BE CONTACTED**. For faster results, call 1-800-497-4856.

Change ❑ Cancellation ❑

I understand that deductions will continue until request is processed. Premiums will not be refunded. Changes coincide with premium adjustments

Are you covered by other insurance?
Yes ❑ No ❑

General Information Section
Complete Entire Section (Please Print)

Employee's Name (Please Print)	Sex	Social Security Number	❑ Married ❑ Single

Home Address (Street or PO Box)	City	State	Zip Code

Date of Birth (MM/DD/YY)	Telephone	Signature	Date
	( )		

Beneficiary's Full Name	Relationship

Dependent Coverage Section (Please Use Additional Sheets If Necessary)

Dependent's Name	Relation	Sex	Date of Birth (MM/DD/YY)	Social Security Number
	Spouse			/ /
	Child			/ /
	Child			/ /
	Child			/ /

Health Benefits Offered
(Must elect same level of coverage for all benefits. Example: If family medical is selected, family options apply, etc.)

Coverage	Employee	Employee + One	Family
Medical	$19.98	$42.84	$57.84
Hospital Indemnity	$3.45	$7.53	$10.11
Dental	$3.84	$7.38	$12.92
Disability	$4.20	N/A	N/A
Term Life	$0.60	$0.90	$1.80
Vision	$0.50	$0.70	$1.00
Accident	$2.04	$4.79	$4.79
Critical Illness	$2.20	$3.25	$3.30
Total Weekly Deduction			

Employee's Signature:	Social Security Number: / /	Date: