Employee Enrollment Card

601 Poydras Street
New Orleans, LA 70130

8310 Clinton Park Drive
Fort Wayne, IN 46825

Name of Employer		Employment Date	Effective Date Annual Maximum
Name of Insured		Date of Birth	☐Male ☐Female
Social Security Number	☐Employee ☐Retiree	☐Surviving Spouse ☐Board Member	Group #
Spouse's Name	Date of Birth	Dependent Name	Date of Birth
Dependent Name	Date of Birth	Dependent Name	Date of Birth
Dependent Name	Date of Birth	Dependent Name	Date of Birth
Primary Beneficiary for AD&D		Relationship	
Contingent Beneficiary for AD&D		Relationship	Data Input in Lx

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify that my eligible dependents and I are covered by a Base Health Plan as defined in the Employer's Participation Agreement and I Hereby request to be insured under the group policy (ies) issued.
P

_____ _____
Date Signature

BeniComp *Select* Benefits will be administered in accordance with the Base Health Plan. The Base Health Plan must have minimum benefits as follows:

- $1,000,000 lifetime maximum per person; subject to:
- an annual deductible not to exceed $5,000 per person; and
- a maximum out of pocket per individual not to exceed $ 10,000

Eligible major medical charges must include semi-private room and board (in full), and extended care (in full). The Base Health Plan must provide coverage for usual, customary and reasonable charges for all professional services and supplies.