

## VOLUNTARY SUPPLEMENTAL BENEFITS ENROLLMENT

<b>Employer:</b>	<b>Employer Phone Number:</b>
<b>Employee:</b>	

### Supplemental Benefit Options

#### OUTPATIENT + ACCIDENT

<p><b>Outpatient Benefits</b> Covers Office Visit, Physician, outpatient and outpatient facility charges Outpatient and Accident Benefits paid until HDHP deductible is met</p>	<p><b>Total Calendar Year Outpatient Benefit as selected below</b></p> <ul style="list-style-type: none"> <li>\$25 Doctor's Office Visit Copay per visit – Plan pays 100% of covered in-network charges (80% of out-of-network)</li> <li>Other Outpatient Benefits begin after a \$250 deductible</li> <li>Plan pays 80% in-network (50% out-of-network)</li> </ul>
<p><b>Accident Benefits</b> Covers Doctor's office, urgent care clinic or emergency room charges</p>	<p>Plan pays 100% (deductible waived) for accidents up to an <b>additional \$1,000 per Calendar year</b> for each insured</p>

#### HOSPITAL INDEMNITY

<p><b>Hospital Indemnity Benefit</b> Cash benefit paid for inpatient confinement in a hospital Benefit paid even after HDHP deductible is met</p>	<p><b>Plan pays a cash benefit as selected below</b></p>
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### Select Your Benefits

<p><b>Outpatient + Accident – check one benefit or check “None” if not enrolling</b></p> <p><input type="checkbox"/> None- I elect not to enroll for these benefits</p> <p><input type="checkbox"/> \$1,500 Outpatient Benefit + \$1,000 Accident Benefit</p> <p><input type="checkbox"/> \$2,500 Outpatient Benefit + \$1,000 Accident Benefit</p> <p><input type="checkbox"/> \$3,500 Outpatient Benefit + \$1,000 Accident Benefit</p>
<p><b>Hospital Indemnity – check one benefit or check “None” if not enrolling</b></p> <p><input type="checkbox"/> None- I elect not to enroll for these benefits</p> <p><input type="checkbox"/> \$2,500 Hospital Indemnity Benefit (\$500 per day)</p> <p><input type="checkbox"/> \$5,000 Hospital Indemnity Benefit (\$1,000 per day)</p>

**Employee Statement:** I acknowledge that this enrollment form supplements and is a part of my Employee Application for my employer's high deductible health plan (HDHP); I am voluntarily enrolling in the above selected supplemental benefits, or voluntarily waiving my right to participate in those benefits (by selecting “none”); the voluntary supplemental benefits can only be discontinued, added or changed during the annual open enrollment or upon a HIPAA qualifying event (as explained in my Employee Application); if I have dependents participating in the HDHP, those dependents must also participate in any supplemental benefits selected above; and only my dependents covered by the HDHP can participate in the supplemental benefits.

<b>Employee Signature:</b>	<b>Date:</b>
<b>Employee Name (please print):</b>	