CONCIERGE Third Party Administrator

FRONTLINE HRO STAFFING GROUP HOLDINGS

Concierge Enrollment Form

Employer Group: Staffing Group Holdings

Tell us about yourself!

Last Name	First Name	Birthday (MM/DD/YYYY)	Social Security Number
Mailing Address	**City, State, Zip**		**Gender**
E-mail	**Phone Number**	**Date of Hire**	**Location**

Coverage Information (check all that apply)

Preventive Plus Plan	Employee Only ☐	Employee/Spouse ☐	Employee/Child ☐	Family ☐
Limited Medical Plan 200	Employee Only ☐	Employee/Spouse ☐	Employee/Child ☐	Family ☐
Dental Plan	Employee Only ☐	Employee/Spouse ☐	Employee/Child ☐	Family ☐
Vision Plan	Employee Only ☐	Employee/Spouse ☐	Employee/Child ☐	Family ☐

Dependent Information (if applicable)

Dependent Name	Gender	Birth Date (MM/DD/YYYY)	Relationship	Social Security Number
Dependent Name	**Gender**	**Birth Date (MM/DD/YYYY)**	**Relationship**	**Social Security Number**
Dependent Name	**Gender**	**Birth Date (MM/DD/YYYY)**	**Relationship**	**Social Security Number**

Beneficiary Information (if you selected the Term Life Insurance plan, indicate a Life Insurance Beneficiary below)

Beneficiary Name	Relationship	Home/Cell Phone

Pricing per pay Period (52 pay periods)

Preventive Plus Plan	Employee $21.12 ☐	Employee/Spouse $43.04 ☐	Employee/Child $38.42 ☐	Family $59.19 ☐
Limited Medical Plan 200	Employee $20.19 ☐	Employee/Spouse $29.54 ☐	Employee/Child $27.23 ☐	Family $35.54 ☐
Dental Plan	Employee $7.15 ☐	Employee/Spouse $14.08 ☐	Employee/Child $14.08 ☐	Family $21.00 ☐
Vision Plan	Employee $4.27 ☐	Employee/Spouse $8.19 ☐	Employee/Child $8.19 ☐	Family $11.65 ☐

Employee Signature

Employee Signature	Date

By signing this document I authorize my employer to deduct the selected amount from my paycheck weekly.

Declination of Health Coverage

Reminder: Preventive plans do not affect other coverages.
You can have both your current coverage and a Preventive plan.
Rejection of coverage for medical coverage for one of the following reasons:

☐ Coverage under a spouse's insurance plan - Name of Carrier: _____

☐ Enrolled in any other insurance carrier plans - Name of Carrier: _____

☐ Medicare ☐ YES ☐ NO

☐ Other (explain): _____

The coverage has been explained to me by my employer. I have been given the opportunity to apply for the coverage available and have chosen not to enroll.

Employee Signature	Date

Special Enrollment Notice:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Concierge Benefit Services at 1-888-820-5687.

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