Focus Workforce Management, Inc.
FWM

Return completed forms to:
855-899-5709 or
faxing@benefitsinacard.com

Benefits in a Card™

A Limited Benefit Plan
This is not Major Medical Coverage

ENROLLMENT FORM

1-800-497-4856 * M-F 8AM-9PM EST (Bilingual Agents on Staff)

No coverage during period without Payroll deduction or direct payment to Benefits-In-A-Card
COBRA eligible after 4 consecutive weeks without payroll deductions or direct payments (Does not apply to Disability Income Coverage)

Coverage Level- *Applies to all Benefits Elected*	
Select **One**	
Employee	☐
Employee + Spouse	☐
Employee + Children	☐
Employee + Family	☐
No Coverage. I elect NOT to participate	☐
Are you covered by other Insurance? Yes ☐ No ☐	

Coverage Options	
Medical Options	
Medical **–** MEC *(ACA Compliant Plan)*	☐
Insure Plus Plans – May elect ONE with or without a MEC election *(ACA compliant only if chosen with MEC Plan)*	
Medical – Insure Plus	☐
Medical – Insure Plus Enhanced	☐
Medical – Insure Plus Premier	☐
Additional Benefit Options	
Dental	☐
Disability *(Available for Employee Only)*	☐
Life	☐
Vision	☐
Critical Illness	☐
Accident	☐

General Information Section

Complete Entire Section (Please Print)

Employee's Name (Please Print)	Sex	Social Security Number	Country of Citizenship

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

Date of Birth (MM/DD/YY)	Telephone	Email Address
	( )	

Beneficiary's Full Name	Relationship

Dependent Information (Please Use Additional Sheets if Necessary)

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

Benefits Through Your Employer

Coverage	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Medical – MEC	$15.32	$18.37	$18.84	$21.52
Medical – Insure Plus	$15.05	$23.67	$21.95	$31.07
Medical – Insure Plus Enhanced	$21.43	$35.77	$31.00	$45.84
Medical – Insure Plus Premier	$31.02	$53.97	$44.28	$67.72
Dental Benefit	$3.71	$7.14	$9.79	$14.75
Disability Benefit	$4.02	N/A	N/A	N/A
Term Life Benefit	$1.79	$2.23	$2.23	$2.57
Vision Benefit	$2.15	$4.35	$4.94	$7.62
Critical Illness Benefit	$2.56	$3.94	$2.83	$4.20
Accident Benefit	$2.04	$3.01	$3.06	$4.62

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. Premium will not be refunded. Changes coincide with premium adjustments.

Signature ____________________ Date ____________________