

AMERICAN PUBLIC LIFE INSURANCE COMPANY

6303 N. Portland, Suite 402, Oklahoma City, OK 73112

Toll Free (800) 256-8606

We are required to provide you with the following consumer protection federal notice.

# IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you’re sick or hospitalized. You’re still responsible for paying the cost of your care.

* The payment you get isn’t based on the size of your medical bill.
* There might be a limit on how much this policy will pay each year.
* This policy isn’t a substitute for comprehensive health insurance.
* Since this policy isn’t health insurance, it doesn’t have to include most Federal consumer protections that apply to health insurance.

# Looking for comprehensive health insurance?

* **Visit HealthCare.gov online** or call **1-800-318-2596** (TTY: 1-855- 889-4325) to find health coverage options.
* To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

# Questions about this policy?

* For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website (NAIC.org) under “Insurance Departments.”
* If you have this policy through your job, or a family member’s job, contact the employer.

DN154APL



Return completed forms to: 855-899-5709 or

|  |
| --- |
| **Focus Workforce Management, Inc** |
| **FWM** |

faxing@benefitsinacard.com

A Limited Benefit Plan

This is not Major Medical Coverage

|  |
| --- |
| 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 (Does not apply to Disability Income Coverage) |

**ENROLLMENT FORM**

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

**Coverage Elections**

**Premiums displayed are weekly deductions**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Plan Options | Employee | Employee+ Spouse | Employee+ Children | Family | 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** |
| **Medical:** |
| Stay Healthy /MEC TeleRx *(ACA Compliant Plan)* |  | $17.21 |  | $20.26 |  | $20.73 |  | $23.41 |
| Stay Healthy/MEC Enhanced Basic (*ACA Compliant Plan)* |  | $35.11 |  | $53.76 |  | $56.41 |  | $72.93 |
| **VIP Plans –** May elect ONE with or without a Stay Healthy/MEC TeleRx **or**Stay Healthy MEC Enhanced Basic Plan election |
| VIP Standard with Virtual Primary Care (VPC) |  | $19.55 |  | $35.48 |  | $29.23 |  | $48.33 |
| VIP Plus with Virtual Primary Care (VPC) |  | $33.54 |  | $68.61 |  | $53.29 |  | $94.80 |
| **OR:** |
| Stay Healthy/MEC Enhanced (*ACA Compliant Plan*) |  | $44.99 |  | $75.30 |  | $72.69 |  | $102.94 | Change  Cancellation  |
| MVP *(ACA Compliant Plan)* **Contact BIC to enroll: 1-800-497-4856** |
| **Additional Benefit Options:** |
| I understand that deductions will continue until request is processed. Premium will not be refunded. Changes coincide with premium adjustments. |
| Dental |  | $3.64 |  | $7.01 |  | $9.62 |  | $14.49 |
| Disability *(Must be working 20 hours or more to qualify)* |  | $3.95 | NA | NA | NA |
| Life |  | $2.11 |  | $2.54 |  | $2.54 |  | $3.17 |
| Vision |  | $2.15 |  | $4.35 |  | $4.94 |  | $7.62 |
| Critical Illness |  | $2.51 |  | $3.87 |  | $2.78 |  | $4.13 |
| Accident |  | $2.01 |  | $2.95 |  | $3.01 |  | $4.54 |
| Behavioral Health |  | $1.50 |  | $1.50 |  | $1.50 |  | $1.50 |  |
| IDX Social Plus |  | $1.98 |  | $2.70 |  | $2.70 |  | $2.70 |
| FreeRx with Virtual Primary Care (VPC) |  | $9.99 |  | $10.99 |  | $10.99 |  | $10.99 |
| **Coverages are effective on the Monday following your payroll deduction for benefits** |

 **No Coverage: I choose not to participate**

**General Information Section Complete Entire Section (Please Print)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Employee’s First Name | MI | Last Name | Gender | Social Security Number | Country of Citizenship |  | Married |
|  |  |  |  |  |  |  | Single |
| Home Address (Street or PO Box) | City | State | Zip Code |
|  |  |  |  |
| Date of Birth (MM/DD/YY) | Email Address | Telephone |
|  |  | ( ) |
| Beneficiary’s Full Name | Relationship |
|  |  |
|  |
| **Dependent Coverage Section (Please Use Additional Sheets if Necessary)** |
| Dependent’s First Name | MI | Last Name | Relation | Gender | Social Security Number | Country of Citizenship | Date of Birth (MM/DD/YY) |
|  |  |  | Spouse |  |  |  |  |
|  |  |  | Child |  |  |  |  |
|  |  |  | Child |  |  |  |  |
|  |  |  | Child |  |  |  |  |
|  |  |  | Child |  |  |  |  |
|  Signature:  |  |  |  |  |  Date:  |

2025 Enrollment

Are you covered by other Insurance?

Yes  No 