First Choice Staffing

# Do You See Health Coverage In Your Future?

# We Do.

## HM Care Advantage Is Here. And It's Worth A Look.

Your employer is now offering HM Care Advantage, a limited benefit medical plan created to help meet your basic health insurance needs.

**See Inside.**

**Interested in coverage? Don't Delay.**

# Offering Health Coverage to you

## Have an existing condition?

No worries. You can't be turned down for coverage. And you won't be required to answer any questions about your health. HM Care Advantage can pay benefits directly to you or your health care provider. You decide what works best.

## Common health needs are covered.

- Physician office visits
- Surgery/anesthesia
- Outpatient diagnostic testing
- Inpatient hospitalization
- Additional first day admission benefit

## Need to focus on wellness?

You can have an opportunity to visit a physician before a minor illness or injury turns into something more serious. HM Care Advantage also offers a well-visit to the doctor (such as for a routine annual physical exam). Toll-free 24/7 telephone service for information and advice, online health resources and discounts for pharmacy, vision, fitness and wellness products and services also are available.

HM Care Advantage pays a fixed amount for medical services. It does not provide major medical or comprehensive medical insurance. You must be eligible to enroll. Benefits include those required by New York State Law.

## Ready to enroll?

**1. By phone.**
Call 800.481.9979.

Our Customer Service Representatives are available to answer your questions and enroll you in HM Care Advantage from 8:30 a.m. to 7 p.m. Eastern time, Monday through Friday.

**2. By mail.**
Complete the attached HM Care Advantage enrollment form and return as instructed.

**New hires**
Newly hired employees have 30 days from the date they become eligible to enroll in the plan. Coverage becomes effective on the first of the month following enrollment if you enroll by the 15th of the month.

**Questions?**
Contact the Call Center at **800.481.9979.**

HM Life Insurance Company of New York is a member of HM Insurance Group, a Highmark Company.

**HM CARE ADVANTAGE**
A LIMITED BENEFIT MEDICAL PLAN

**First Choice Staffing**

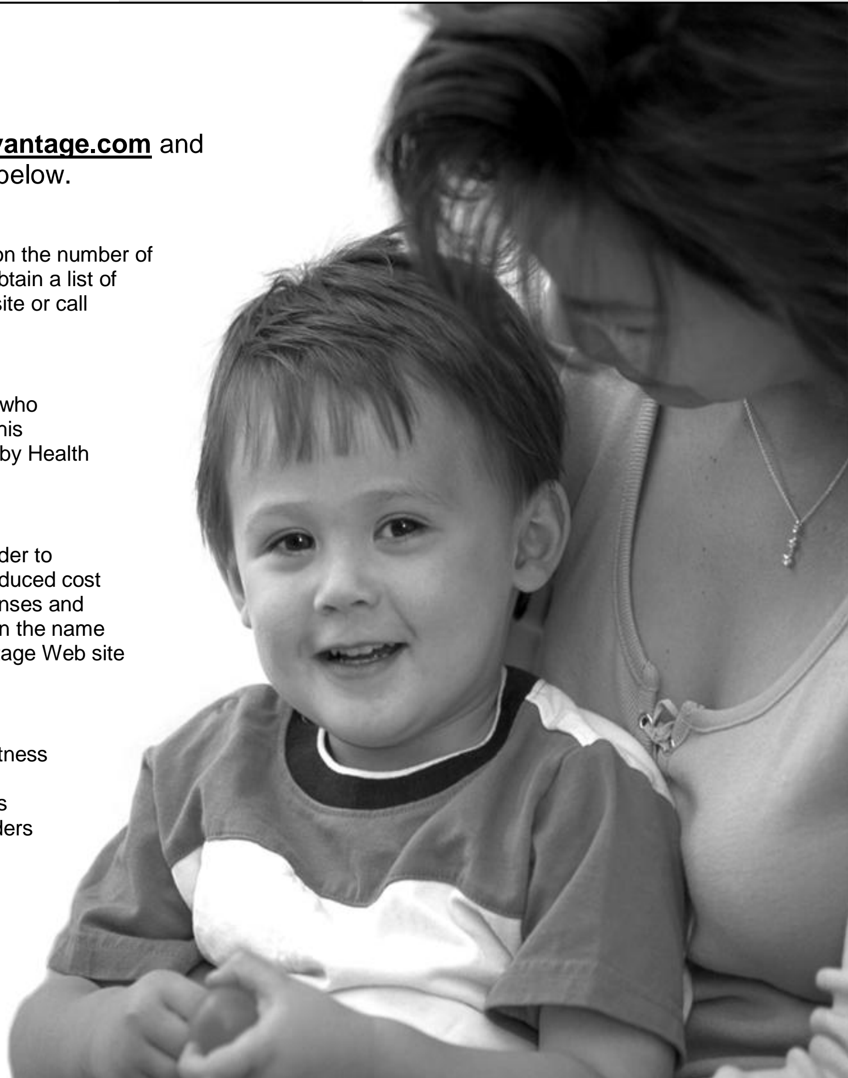
This benefit summary is designed to provide an overview of the different plan options that are available and the cost for each of the plans. Benefits shown are per calendar year per covered person. The calendar year is the employer defined benefit cycle.
HM Care Advantage pays a fixed amount for medical services. Employees are responsible for additional balances not covered by insurance. Employees and spouses ages 18 to 69 years may enroll for coverage. Benefits terminate at age 70.

| Benefit Summary | Plan 1 | Plan 2 | Plan 3 |
|---|---|---|---|
| **Daily In-Hospital**<br>Pays amount shown for hospitalization in a licensed facility as a result of an accident or sickness. *(Total number of In-Hospital days and Intensive Care Unit days combined is limited to 30 days.)* | $350 per Day<br>30 Days | $750 per Day<br>30 Days | $1,250 per Day<br>60 Days |
| **Additional Daily Benefit for First Day of Hospital Confinement**<br>Pays an amount equal to one day of the Daily In-Hospital benefit for the first day of confinement. | $350 First Day<br>1 Admission | $750 First Day<br>1 Admission | $1,250 First Day<br>4Admission |
| **Office Visits – Physician/Licensed Practitioner**<br>Pays amount shown for sickness or injury visits to a doctor or licensed practitioner; also includes one wellness visit. May be used for services provided in a hospital emergency room or urgent care center. | $60 per Visit<br>6 Visits | $80 per Visit<br>8 Visits | $80 per Visit<br>8 Visits |
| **Inpatient Visits – Physician**<br>Pays amount shown for one physician visit per day while confined to a hospital for a covered sickness or accident. | $80 per Visit<br>5 Visits | $100 per Visit<br>6 Visits | $100 per Visit<br>6 Visits |
| **Surgery**<br>Pays amount shown for surgical procedures at a licensed hospital, outpatient facility or physician's office as shown on the Schedule of Surgical Benefits. | $1,000 Max. per Surgery Based on Schedule<br>1 Surgery | $2,500 Max. per Surgery Based on Schedule<br>2 Surgeries | $3,500 Max. per Surgery Based on Schedule<br>3 Surgeries |
| **Anesthesia**<br>Pays amount shown for anesthesia services provided during a surgical procedure at a licensed hospital, outpatient facility or physician's office. | 20% of Scheduled Surgical Benefit | 20% of Scheduled Surgical Benefit | 20% of Scheduled Surgical Benefit |
| **Hospital Emergency Room**<br>Pays amount shown for a non-work related injury or illness visit to an emergency room of a hospital or licensed facility. Limit one illness visit per calendar year. Additional illness visits paid at Office Visits benefit amount. | $350 per Visit<br>1 Visit | $500 per Visit<br>1 Visit | $500 per Visit<br>2 Visits |
| **Outpatient Diagnostic Testing**<br>Pays amount shown per day for laboratory, imaging and testing services for accident or illness diagnosis in an outpatient setting. | $125 per Testing Day<br>2 Days | $150 per Testing Day<br>3 Days | $250 per Testing Day<br>3 Days |
| **Outpatient Hospital Services**<br>Pays amount shown per treatment day for therapies and treatments performed on an outpatient basis. | $225 per Treatment Day<br>1 Day | $250 per Treatment Day<br>2 Days | $350 per Treatment Day<br>3 Days |
| **Wellness Screening Test**<br>Pays amount shown for colonoscopy, flexible sigmoidoscopy or bone densitometry. | $50 per Test<br>1 Test | $100 per Test<br>1 Test | $100 per Test<br>1 Test |
| **Wellness Service**<br>Pays amount shown for Pap test, prostate-specific antigen test (PSA), mammogram or immunization. | $50 per Service<br>1 Service | $50 per Service<br>1 Service | $50 per Service<br>1 Service |
| **Ambulance Service**<br>Pays amount shown for ground or air transportation by a licensed ambulance service. | $300 per Trip<br>1 Trip | $300 per Trip<br>1 Trip | $300 per Trip<br>2 Trips |

| **Benefit Summary *Cont.*** | **Plan 1** | **Plan 2** | **Plan 3** |
|---|---|---|---|
| **Home Health Care**<br>Pays amount shown for home visits for nursing care, home health aid service, physical, speech and occupational therapies, nutritional counseling and medical social services when prescribed by the covered person's physician. | $50 per Visit<br>40 Visits | $50 per Visit<br>40 Visits | $50 per Visit<br>40 Visits |
| **Treatment for Chemical Abuse and Dependency**<br>Pays amount shown for the treatment of chemical abuse and dependency, including alcohol. 20 of the outpatient treatment days may be used by family members; each family member treatment day reduces the number of allowable outpatient treatment days for this benefit. | Inpatient: $350 per Day<br>7 Rehab Days<br>30 Treatment Days<br>Outpatient: $60 per Treatment Day<br>60 Days | Inpatient: $750 per Day<br>7 Rehab Days<br>30 Treatment Days<br>Outpatient: $80 per Treatment Day<br>60 Days | Inpatient: $1,250 per Day<br>7 Rehab Days<br>30 Treatment Days<br>Outpatient: $80 per Treatment Day<br>60 Days |
| **Skilled Nursing Facility**<br>Pays amount shown for confinement in a skilled nursing facility due to a covered accident or sickness. | $175 per Day<br>60 Days | $ 375 per Day<br>60 Days | $625 per Day<br>120 Days |
| **Hospice/End-of-Life Care**<br>Pays amount shown for the appropriate treatment incurred by a covered person diagnosed with advanced cancer for acute care services at a licensed acute care facility specializing in the treatment of terminally ill patients. Bereavement visits are for the covered person’s family members. | $50 per Day<br>210 Days<br>(Lifetime max.)<br>5 Bereavement | $50 per Day<br>210 Days<br>(Lifetime max.)<br>5 Bereavement | $50 per Day<br>210 Days<br>(Lifetime max.)<br>5 Bereavement |
| **Benefits Required by New York State Law**<br>New York state law requires that benefits are paid for certain conditions/services. A list of those conditions/services along with an explanation as to how they are covered in this plan is shown on page 6. | See Page 6 | See Page 6 | See Page 6 |
| **The following benefits are not required by New York state law but were selected by your employer to be included in your plan.** | | | |
| **Provider Network Discounts**<br>Covered persons will receive contracted discounts from the usual and customary fees from network physicians, hospitals, outpatient diagnostic imaging and laboratory providers. Service is provided by MultiPlan. Information on participating providers can be obtained by going to www.hmcareadvantage.com and clicking on Member Information or by calling 800.672.2140. | Included | Included | Included |
| **Daily Intensive Care Unit**<br>Pays amount shown for inpatient hospital intensive care services, including intensive care (ICU), coronary care (CCU), neonatal intensive care (NICU) and pediatric intensive care (PICU). *(Total number of In-Hospital days and Intensive Care Unit days combined is limited to amount of Daily In-Hospital days.)* | $700 per Day<br>Replaces In-Hospital Days | $1,500 per Day<br>Replaces In-Hospital Days | $2,500 per Day<br>Replaces In-Hospital Days |

This benefit summary provides a very brief description of the important features of your coverage. This is not the insurance contract, but only a summary of coverage. Only the Group Policy or Participation Certificate and the Certificate of Insurance contain the actual provisions, including exclusions and limitations, which control the terms of your coverage. This means that the Group Policy or Participation Certificate and the Certificate of Insurance set forth in detail the rights and obligations of both you, the Group Policyholder or Participating Employer and HM Life Insurance Company. Therefore, if you become insured, it is important that you READ YOUR CERTIFICATE CAREFULLY.

| Weekly Payroll Deduction | Plan 1 | Plan 2 | Plan 3 |
|---|---|---|---|
| **Employee** | $24.05 | $42.55 | $65.73 |
| **Employee + Spouse** | $45.43 | $81.51 | $126.73 |
| **Employee + Child(ren)** | $45.67 | $81.75 | $126.97 |
| **Family** | $67.03 | $120.67 | $187.95 |
| **Spouse Only** | $24.05 | $42.55 | $65.73 |
| **Spouse + Child(ren) Only** | $45.67 | $81.75 | $126.97 |
| **Child(ren) Only** | $23.93 | $41.52 | $63.55 |



## Additional benefits included with your HM Care Advantage plan…

For additional information, go to **www.hmcareadvantage.com** and click on Member Information, or call the numbers below.

### Pharmacy Discount Card

Provides discounts for brand and generic drugs with no limits on the number of prescriptions filled. Service is provided by Caremark, Inc. To obtain a list of participating pharmacies, go to the HM Care Advantage Web site or call 877.321.2652.

### Health Information On-Call

Access to a toll-free telephone line to talk with health coaches who provide information and support for health-related concerns. This service is available 24/7, 365 days a year. Service is provided by Health Dialog Services Corporation.

### Vision Discount*

Covered persons must use a participating network vision provider to receive this benefit which includes a covered eye exam and reduced cost for other services such as frames, spectacle lenses, contact lenses and laser vision care. Service is provided by Davis Vision. To obtain the name of a Davis Vision provider near you, go to the HM Care Advantage Web site or call 800.999.5431.

### Complementary Wellness Discount Program

Discounts on health-related products and services, including fitness center memberships, chiropractic care, acupuncture, vitamins, massage therapy and more. Service is provided by Healthways WholeHealth Networks, Inc. To find participating service providers and retail outlets, go to the HM Care Advantage Web site.

### Health Information On-Line

Internet site providing lifestyle improvement programs, health information and resources on a range of topics, including tobacco cessation, nutrition, weight management, stress management, chronic conditions, back pain, insomnia, depression, diabetes and other general health topics. Service is provided by HealthMedia® Inc.

*Replaced by insured vision coverage when insured coverage is offered.

HM Care Advantage is an HM Life Insurance Company of New York product administered by Key Benefit Administrators (KBA). The medical portion of the product provides group limited medical indemnity benefits; it does not provide major medical or comprehensive medical insurance. Based on the plan selected, Medical and Vision coverages are underwritten by HM Life Insurance Company of New York, New York, NY, under policy form series HM407, HL902 or similar. Dental coverage is underwritten by Renaissance Health Insurance Company of New York, New York, NY, under policy form series DT-300A-NY. Administrative and/or customer support services when available are provided: for Health Information On-Call – Health Dialog Services Corporation; for Complementary Wellness Discount Program – Healthways WholeHealth Networks, Inc; for Health Information On-Line – HealthMedia® Inc.; for Pharmacy Discount Card – Caremark, Inc; for Vision – Davis Vision; for Provider Network Discounts – MultiPlan. Other administrative and/or customer support services may be provided by HM Benefits Administrators, Pittsburgh, PA. Certain exclusions and limitations may apply. See your certificate or other evidence of coverage for details. Coverage or service requested or the use of an association, franchise, trust or union may not be available.

## HM CARE ADVANTAGE– BENEFITS REQUIRED BY NEW YORK STATE LAW

New York state law requires that benefits are paid for the following conditions/services. Benefits for these conditions/services will be paid as other benefits in the Policy; unless otherwise noted, benefits are limited by the number of services shown in the Benefits Summary and the accompanying descriptions.

MATERNITY CARE ─ maternity care, including hospital, surgical or medical care to the same extent that coverage is provided for sickness. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits, Inpatient Visits, Daily In-Hospital, etc., as shown in the Benefit Summary; however, in the event that benefits are exhausted, additional benefits will be paid at the applicable benefit amount for inpatient hospital coverage for the mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section and at least 96 hours after a caesarean section; and two additional benefits will be paid for prenatal visits or parent education.

POST MASTECTOMY RECONSTRUCTION ─ all stages of reconstructive breast surgery after a mastectomy for the breast on which the mastectomy has been performed; reconstructive breast surgery performed on a non-diseased breast to establish symmetry also is included. The amount paid and the number of payments is limited to the applicable benefit, i.e., Inpatient Visits, Daily In-Hospital, Surgery, etc., as shown in the Benefit Summary.

PREADMISSION TESTING ─ coverage for tests performed in a hospital facility prior to scheduled surgery. This benefit is paid at the amount shown in the Benefit Summary for the Outpatient Diagnostic Testing and is limited by the number of allowable test days.

SECOND SURGICAL OPINION ─ an opinion by a qualified physician regarding the need for surgery. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits or Inpatient Visits, as shown in the Benefit Summary.

PRE-HOSPITAL EMERGENCY SERVICES ─ pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service. This benefit is paid at the amount shown in the Benefit Summary for the Ambulance Service benefit and is limited by the number of allowable trips.

DIABETES SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT EDUCATION ─ equipment and supplies for the treatment of diabetes and diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits, Outpatient Services, etc., as shown in the Benefit Summary.

MASTECTOMY CARE ─ inpatient care for a person under a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy; includes prosthesis and physical complications for all stages of mastectomy, including lymphomas. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Inpatient Visits, Daily In-Hospital, Surgery, etc., as shown in the Benefit Summary.

SECOND MEDICAL OPINION FOR CANCER DIAGNOSIS ─ an opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, for the treatment of cancer in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits, Inpatient Visits, Outpatient Diagnostic Testing, etc., as shown in the Benefit Summary.

MEDICAL CONDITIONS LEADING TO INFERTILITY ─ hospital, surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits, Inpatient Visits, Daily In-Hospital, Surgery, etc., as shown in the Benefit Summary.

MENTAL/NERVOUS CONDITIONS ─ diagnosis and treatment. This benefit will provide up to 30 inpatient treatment days, and 20 outpatient visits, three of which can be used for psychiatric emergency visits. Inpatient treatment days will be paid at the Daily In-Hospital amount, and outpatient visits will be paid at the Office Visits amount shown in the Benefit Summary. This benefit is paid regardless of the number of available in-hospital days or office visits.

CONTRACEPTIVE DRUGS AND DEVICES ─ drugs and devices, including generic equivalents, approved by the Food and Drug Administration (FDA). This benefit is paid the same as the Office Visits benefit when the drugs or devices are provided by a physician and is limited by the number of allowable visits.

MAMMOGRAPHY SCREENING ─ if recommended by a physician, a mammogram at any age for a person with prior history of breast cancer or who has a first degree relative with a prior history of breast cancer; single baseline mammogram for persons aged 35 through 39 inclusive; annual mammogram for persons 40 and older. This benefit is paid at the amount shown in the Benefit Summary for the Wellness Service, and it is paid regardless of the number of available services.

PROSTATE CANCER SCREENING ─ standard diagnostic test, digital rectal examination and a prostate-specific antigen (PSA) test at any age for men having a prior history of prostate cancer; annual examination including a digital rectal examination and a PSA test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. This benefit is paid at the amount shown in the Benefit Summary for the Outpatient Diagnostic Testing, and it is paid regardless of the number of available testing days.

CANCER DRUGS NOT APPROVED BY THE FDA ─ for the treatment of a type of cancer for which the drug is recognized for treatment of a specific type of cancer for which the drug has been prescribed in one of the following reference compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Drug Information or recommended by review article or editorial comment in a major peer reviewed professional journal. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits, Inpatient Visits, Outpatient Hospital Services, etc., as shown in the Benefit Summary.

CERVICAL CYTOLOGY SCREENING ─ annual cervical cancer screening (Pap test) for women 18 years of age and older. This benefit is paid at the amount shown in the Benefit Summary for the Outpatient Diagnostic Testing and the Office Visits benefits and it is paid regardless of the number of available testing days or office visits.

CHIROPRACTIC CARE ─ care provided by a New York State licensed practitioner for the purpose of removing nerve interference, and the effects thereof, where such interferences are the result of or related to distortion, misalignment or subluxation of or in the vertebral column. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits or Inpatient Visits, as shown in the Benefit Summary.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT IF REQUIRED BY LAW ─ The amount paid and the number of payments is limited to the applicable benefit, i.e., Office Visits, Inpatient Visits, Outpatient Hospital Services, etc., as shown in the Benefit Summary.

PREVENTIVE AND PRIMARY CARE SERVICES ─ an initial hospital check-up, well-child visits and necessary immunizations from birth to age 19. The amount paid and the number of payments for this benefit is limited to the applicable benefit, i.e., Office Visits, Inpatient Visits, Daily In-Hospital, etc., as shown in the Benefit Summary. After 31 days, the child(ren) must be enrolled for this benefit to continue to be payable.

## HM CARE ADVANTAGE– MEDICAL EXCLUSIONS & LIMITATIONS

The following will not be Covered Expenses under this Indemnity Medical Benefit unless specifically provided elsewhere in the Policy:

Treatment that is solely for the purpose of rest care or custodial care and any associated transportation;

Cosmetic surgery; this exclusion does not apply to: Cosmetic surgery resulting from an accident; Reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; Reconstructive surgery because of a congenital defect or anomaly that results in a functional defect of a covered dependent child; With respect to a mastectomy: All stages of reconstruction of the breast on which the mastectomy has be performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Treatment of physical complications for all stages of the mastectomy, including lymphedema; Coverage and determinations with respect to cosmetic surgery are subject to utilization review and external appeal requirements of New York Law.

Routine eye examinations or fitting of glasses or contact lenses;

Hearing examinations or fitting of hearing aids;

Dental examinations or dental care other than expenses resulting from a Covered Accident within 12 months of the Covered Accident's occurrence and other than dental care or treatment necessary due to congenital disease or anomaly;

Suicide or any attempt thereat or any intentionally self-inflicted injury or Sickness, unless as a result of a medical condition or an act of domestic violence;

Participation in a riot or insurrection;

Participation in a felony or assault;

Air travel, except: As a fare-paying passenger on a commercial airline on a regularly scheduled route; or On a charter flight operated by a scheduled airline;

An act of war, whether declared or undeclared, or while performing police service in the Armed Forces or units auxiliary thereto;

An accident or sickness arising out of and in the course of any occupation for compensation, wage or

profit or expenses which are provided under Workers' Compensation, Occupational Disease or similar law;

Any treatment received or expenses incurred during a period of time that insurance for a Covered Person is not in force;

Any treatment received or expenses incurred after this Policy has terminated;

Any service, supply or treatment that is not provided by or at the direction of a Physician, or is inconsistent with standards of medical practice for the applicable condition;

Treatment of any accident or sickness outside the United States, including its possessions or territories, or the countries of Mexico or Canada.

Services, supplies or treatment not considered Medically Necessary even if ordered by a Physician;

Benefits for services or treatment rendered by any person who is: Employed or retained by the Policyholder; Living in the Covered Person's household; A parent, sibling, spouse or child of a Covered Employee or of His spouse; or A Covered Person treating himself.

# HM CARE ADVANTAGE
## LIMITED BENEFIT MEDICAL PLAN
## ENROLLMENT FORM

Please type or print.

**TO BE COMPLETED BY EMPLOYER**

| Employer Name<br>First Choice Staffing | | Group Number |
|---|---|---|
| Employee's Occupation | Work Location | Employee's Weekly Hours Worked |

**Type of Application** *(check one and complete appropriate information)*:

| ☐ New Enrollment | Date of Employment | Effective Date of Coverage |
|---|---|---|
| ☐ Change | Date of Qualifying Event | Nature of Change/Qualifying Event | Effective Date of Coverage |
| ☐ Annual Enrollment Change | | |
| ☐ Termination | Date of Termination | Reason for Termination |

**TO BE COMPLETED BY EMPLOYEE**

| Employee Name (Last, First, Middle Initial) | Social Security Number | Gender ☐ Male ☐ Female |
|---|---|---|
| Home Address | City | State | Zip Code |
| Telephone Number | Birth Date | Marriage Date | Marriage Status ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated |
| Are you currently a COBRA Participant? ☐ Yes ☐ No | Would you like your Employee Fulfillment Kit provided in English or Spanish (*please check one*)?: ☐English ☐ Spanish | |

**INDEMNITY MEDICAL PLAN**

**Plan Selection**

☐ Plan 1 ☐ Plan 2 ☐ Plan 3 (*if Plan 1, 2 or 3 is selected, sign in **Accepting Coverage** section below.*)

**OR**

☐ Decline Medical Coverage* (*if declining coverage, sign in **Declining Coverage** section below.*)

*If declining, is this due to other coverage? ☐ Yes ☐ No

**ACCEPTING COVERAGE - Read and sign if you are electing any coverage offered here.**

I request coverage under HM Life Insurance Company of New York's group medical indemnity insurance policy. I authorize my employer to deduct from my earnings any required contribution for the insurance coverage. For any coverage elected on a pre-tax basis, I understand that by signing this enrollment form, I am making a binding election and it may only be changed for certain changes in family status as defined in the plan. I understand that participation in a cafeteria plan will reduce my taxable compensation and that as a result I will be paying less Social Security tax which may have a modest effect on my Social Security retirement benefit. I certify that I am employed by the employer named in this form, and that all other information stated above is correct.

Employee's Signature ______________________ Date ______________

**DECLINING COVERAGE - Read and sign if you are declining any coverage offered here.**

Although I have been given the opportunity to apply for any group insurance offered to me through my employer, I have decided not to participate in the coverages I have declined above.

Employee's Signature ______________________ Date ______________

**PLEASE CONTINUE TO PAGE 2**

| Level of Coverage | ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Family<br>***Any of the selections below require completion of the "Proof of Employer Sponsored Health Plan section" below.***<br>☐ Spouse Only ☐ Spouse/Child(ren) ☐ Child(ren) Only |
|---|---|

## PROOF OF EMPLOYER SPONSORED HEALTH PLAN SECTION
**Requires completion of "Spouse and/or Dependent Only" section coverage**

| Name of Employee (Last, First, Middle Initial) | Name of Health Carrier | Effective Date of Employee Only Coverage |
|---|---|---|
| | | |

I verify that I have active medical coverage through my Employer's Sponsored health plan and that I have waived coverage only for my spouse and/or dependents under that plan.

Employee's Signature ______________________ Date ____________

## COVERED DEPENDENTS

| Covered Dependent (Last, First, M.I.) | Social Security Number | Sex | Birth Date | Students' College City, State, # Hours | Graduation Date (if applicable) |
|---|---|---|---|---|---|
| Spouse | | ☐ M ☐ F | | | |
| Dependent | | ☐ M ☐ F | | | |
| Dependent | | ☐ M ☐ F | | | |
| Dependent | | ☐ M ☐ F | | | |
| Dependent | | ☐ M ☐ F | | | |

## FRAUD STATEMENT – Please read carefully.

In New York, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Please return to:**
Key Benefit Administrators, Inc.
P.O. Box 519
Fort Mill, SC 29716
(866) 225-9030

**Underwritten by:**
HM Life Insurance Company of New York
P.O. Box 535061
Pittsburgh, PA 15253-5061
(800) 328-5433
www.hminsurancegroup.com