OPEN ENROLLMENT

EASI Employee Administrative Services, Inc.

EASI is pleased to offer all employees, at no cost to the employer, the option to enroll into our Dental , Vision, Telemedicine, Supplemental Insurance Plans and Flexible Spending Accounts.

All new employees may elect to complete the enrollment forms at the time of hire, however, there is a 60 day grace period before the Dental, Vision and Supplemental Insurance Plans will begin.

If a new employee misses enrollment during the first 60 days or if an existing employee chooses to add coverage, they may do so during open enrollment.

Open Enrollment is November 1st- December 15th, with an effective date of January.

To enroll or if you have any questions please contact EASI

itsEASIpayroll.com

601.956.9764 ◉ 689 Towne Center Boulevard Ridgeland, MS 39157

VISION PLAN

EASI
Employee Administrative Services, Inc.

EyeMed®

	Current Rates
Employee Only	$8.10
Employee + Spouse	$13.82
Employee with One Dependent	$14.54
Employee + 2 or more Dependents	$21.37

itEASIpayroll.com

601-956-9764 ◉ 689 Towne Center Boulevard Ridgeland, MS 39157

Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.
Required sections are marked with an *.
Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name*

Effective Date*^ 01 / 01 / 2020

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Group Number*

Subgroup*

Location Code

Employee Information: to be completed by Employee

Change Type*: ☐ Add ☐ Term ☐ Update Member ID:

Last Name*

Date of Birth* / /

First Name* MI Gender* ☐ Male ☐ Female Phone Number ( ) -

Street Address*

City* State* Zip Code* Social Security Number*^ - -

^Last four digits of Employee's Social Security Number are required.

Employee Email Address:

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1

Change Type*: ☐ Add ☐ Term ☐ Update
Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* Gender*: ☐ Male ☐ Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 2

Change Type*: ☐ Add ☐ Term ☐ Update
Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* Gender*: ☐ Male ☐ Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 3

Change Type*: ☐ Add ☐ Term ☐ Update
Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* Gender*: ☐ Male ☐ Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 4

Change Type*: ☐ Add ☐ Term ☐ Update
Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name* Gender*: ☐ Male ☐ Female

First Name* MI Social Security Number - - Date of Birth* / /

Employee Signature*: _____ Date*: / /

For additional dependents, please complete a second form.

DENTAL PLAN

EASI
EMPLOYEE ADMINISTRATIVE SERVICES, INC.

DELTA DENTAL®

	Current Rates
Employee Only	**$41.92**
Employee with One Dependent	**$81.93**
Employee and Family	**$120.41**

itsEASIpayroll.com

601-956-9764 ◉ 689 Towne Center Boulevard Ridgeland, MS 39157

DELTA DENTAL

Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-521-2651
Fax: 770-641-5393

For Employer Use Only

Effective Date / /	Group No 18113
Full Time Hire Date / /	Sublocation

Check One (**Enrollees can change plans only during open enrollment.)

- ❑ New Hire
- ❑ Open Enrollment
- ❑ Change Dental Plans**
- ❑ COBRA
- ❑ Add/Delete Dependent
- ❑ Terminate Employee Coverage
- ❑ Spouse Employment Change
- ❑ Marital Change
- ❑ Other _____

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce
- ❑ Widowed/Surviving Dependent
- ❑ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Location

Marital Status: Single ❑ Married ❑ Gender: Male ❑ Female ❑ Phone # ( ) —

Do you have dependent children? Yes ❑ No ❑ Are you or your dependents covered under another dental plan? Yes ❑ No ❑

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth (Month) (Day) (Year)
Spouse:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

❑ I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____

FLEXIBLE SPENDING ACCOUNT

EASI
EMPLOYEE ADMINISTRATIVE SERVICES, INC.

FLEXIBLE SPENDING ACCOUNT

Save Money on your out of pocket Medical/Dental or Day Care Expenses!

itsEASIpayroll.com

601-956-9764 ◉ 689 Towne Center Boulevard Ridgeland, MS 39157

Employee Administrative Services, Inc.

2020 FLEXIBLE SPENDING PLAN ELECTION

EMPLOYER NAME: _____

ENROLLMENT PERIOD/PLAN YEAR: JANUARY 1, 2020 THROUGH DECEMBER 31, 2020

Employee Name: _____ Date of Birth: _____

Address: _____

Marital Status: _____ Sex: _____ Contact Phone: _____

☐ I decline to participate in the employer sponsored Flex Plan. I have been given the opportunity to participate, and the benefits of the Plan have been explained to me. I understand that I may only participate at the beginning of the next **Plan Year**.

☐ I elect to participate in the employer sponsored Flex Plan. I agree to and understand that:

Elections cannot be changed during the Plan Year unless there is a change in the family status (marriage, divorce, death of a spouse or child, birth or adoption of a child or a change in spouse's condition of employment: i.e., becomes employed, unemployed, or changes employers).

Salary reduction for the Medical and Dependent Care Expense Reimbursement programs will be credited to my "Flexible Spending Account" and the employer will reimburse me during the Plan Year as I submit paid documentation for incurred expenses, for approved un-reimbursed medical and/or dependent care expenses. I further understand that any amount remaining in my "benefit bank" as of March 2020 will be forfeited to the employer.

The opportunity to change my benefit elections for the following Plan Year will be given to me prior to each Plan Year. ***Benefit selections will continue from one Plan Year to the next without completing a new election form.*** However, if I wish to make a change or decline further participation for the next Plan Year, a new election form is required.

The employer may have to reduce or cancel the amount of my salary reduction or otherwise modify this agreement to satisfy new provisions of the Internal Revenue Code as they may occur during the plan year. Should I terminate my employment and the reimbursements I have received are greater than the amount that has been deposited into my Flexible Spending Account, I agree to reimburse the difference to People Lease.

Having selected the benefits checked below, I hereby elect to be reimbursed for the indicated expenditures and authorize my employer to reduce my gross compensation per pay period in the total amount stated below in conformity with Section 125 of the Internal Revenue Code.

Un-reimbursed Medical/Dental/Vision Expenses *(Not to exceed $2,500 for the 2020 Plan Year)* $_____

Dependent Child Care Expenses *(Not to exceed $5,000 for the 2020 Plan Year)* $ _____

Employee Signature: _____ Date:_____

**************************************FOR OFFICE USE ONLY**************************************

Total number of pay periods remaining in 2020 (12, 24 or 48)

Divide the Total Annual Eligible Expenses amount by the number of pay periods in 2020 to get your pay period election.

$ 0 1 *(Deducted per period/Medical)*

$ 2 0 2 0 *(Deducted per period/Dependent care)*

SUPPLEMENTAL INSURANCES

EASI
EMPLOYEE ADMINISTRATIVE SERVICES, INC.

Aflac
Enroll Now

Colonial Life

itsEASIpayroll.com

601-956.9764 689 Towne Center Boulevard Ridgeland, MS 39157

Enrolling by phone is NOW available for your convenience!

Bobbie McCord – Employee Benefits Consultant for Aflac at
The Sanders Group Inc – 601-991-1115
(Cell) 520.210.1121 or (Email) bobbie@thesandersgroupinc.com

PRE-TAX BENEFITS

Aflac options are available to you that fit your budget – plans offered through payroll deduction at a group discounted rate.

EMPLOYER: _____ **Ph #**_____

Employee Name: _____ **Cell #**_____

I AM INTERESTED IN GETTING MORE INFORMATION ON THE FOLLOWING POLICIES:

☐ **ACCIDENT** ☐ **CANCER** ☐ **CRITICAL ILLNESS** ☐ **HOSPITAL CHOICE**

☐ **LIFE (TERM & WHOLE LIFE)** ☐ **SHORT TERM DISABILITY**

Please Return form to EASI enrollment specialist Jodi Warrington via mail, fax (601-956-6814) or e-mail jwarrington@peoplelease.com

I look forward to working with you in regards to your supplemental planning for you and your family. Please feel free to reach out to me over the next 30+ days to enroll in Aflac coverage.

Bobbie McCord ~ The Sanders Group, Inc

Remember enrolling by phone is Now an Option! 520.210.1121 or 601.991.1115

EASI
Employee Administrative Services, Inc.

Colonial Life

Free for New Colonial Accounts for first year $15/year for existing Colonial clients

☐ MDLIVE

Call MDLive and a PHYSICIAN calls you back within 30 minutes.
Have a doctor visit on the phone and get the prescription you need

Available 24/7/365
Free for Employees AND their Family Members

No Co-pays *Employees SAVE the $20 - $30 co-pay of a doctor visit* *NO doctor office wait*

What are voluntary benefits?

Sometimes called "supplemental insurance," these are often employee-paid. With benefits paid directly to the employee, they can be used to cover lost wages, out-of-pocket expenses and household bills.

☐ **Short-term disability insurance**: Salary insurance for when you can't work
☐ **Cancer insurance**: Featuring a $100 wellness benefit
☐ **Critical Care insurance**: For Heart, Stroke and other major illnesses
☐ **Accident insurance**: With a $100 wellness benefit and $40,000 of accidental death insurance
☐ **Hospital Confinement**: For Hospital deductible plus Outpatient diagnostic and surgery services
☐ **Life insurance:** Term Life, Whole Life and Juvenile Whole Life

EMPLOYER: _____
Employee Name: _____
Employee Phone #: _____
Employee Email: _____

It's time to set a date for your enrollment.

Call or email Jodi Warrington (601-987-3025 or mail@peoplelease.com) to set up an Enrollment Planning session today.