

# OPEN ENROLLMENT



*Payroll • Benefits • Compliance*

People Lease 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



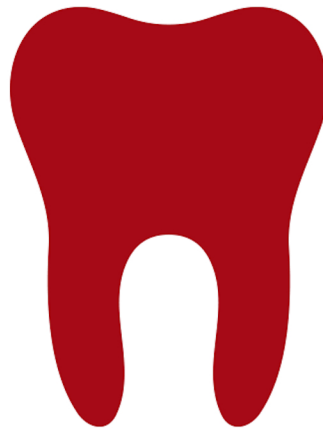
[peoplelease.com](http://peoplelease.com)

601.987.3025 ● 689 Towne Center Boulevard Ridgeland, MS 39157

# People Lease

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# DENTAL PLAN



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

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# Delta Dental Insurance Company

## ENROLLMENT/CHANGE FORM

For Employer Use Only	
Effective Date / /	Group No <b>18113</b>
Full Time Hire Date / /	Sublocation

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

### 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)

### 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 PEOPLE LEASE 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:		
Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>		

### 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)

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 \_\_\_\_\_

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## Current Rates

<b>Employee Only</b>	<b>\$8.10</b>
<b>Employee + Spouse</b>	<b>\$13.82</b>
<b>Employee with One Dependent</b>	<b>\$14.54</b>
<b>Employee + 2 or more Dependents</b>	<b>\$21.37</b>

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VISION PLAN





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## **FLEXIBLE SPENDING ACCOUNT**

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

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2020 FLEXIBLE SPENDING PLAN ELECTION

EMPLOYER NAME: \_\_\_\_\_

PEOPLE LEASE 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.

\$(Deducted per period/Medical)

\$(Deducted per period/Dependent care)

SUPPLEMENTAL INSURANCES

**People  Lease**

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**Aflac**  <sup>®</sup>  
Enroll Now

**Colonial Life** <sup>®</sup>

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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 through People Lease.

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 this form to People Lease or fax to Bobbie at 601.991.1012 or call her at 520.210.1121**

*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**

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

**What Can Be Treated**

**MDLIVE**

- Allergies
- Cough
- Ear problems
- Flu
- Nausea/Vomiting
- Urinary problems / UTI
- Respiratory problems
- Sore throats
- Rashes
- And more

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.

**Check any interested benefits below; then complete form and turn it in by 12/31/18.**

- Dental and Vision insurance:** No rate increases ever, portable (you can keep) until age 75
- 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 People Lease (601-987-3025 or [mail@peoplelease.com](mailto:mail@peoplelease.com)) to set up an Enrollment Planning session today.