DELTA DENTAL

EASI
EMPLOYEE ADMINISTRATIVE SERVICES, INC

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 E A S I 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 _____

Plan Benefit Highlights for: EASI

Group No: 18113

Effective Date: 1/1/2023

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic and Preventive (D & P) and Orthodontics?	$50 per person / $150 per family each calendar year Yes			
Maximums D & P counts toward maximum?	$1,500 per person per calendar year Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits 12 months	Prosthodontics 12 months	Orthodontics 24 months

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Non-Surgical Periodontics (non-surgical gum treatment) Covered Under Basic Services	80 %	80 %
Surgical Periodontics (surgical gum treatment) Covered Under Major Services	50 %	50 %
Oral Surgery Covered Under Major Services	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations, denture reline/rebase and repair	50 %	50 %
Prosthodontics Bridges and dentures	50 %	50 %
Orthodontic Benefits Dependent childrento age 19	50 %	50 %
Orthodontic Maximums	$1,000 Lifetime	$1,000 Lifetime

Rates are effective 1/1/2023 – 12/31/2023	
Employee Only	**$41.92**
Employee & 1 Dependent	**$81.93**
Employee & Family	**$120.41**

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the 90th percentile for non-Delta Dental dentists.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

EyeMed

EASI
EMPLOYEE ADMINISTRATIVE SERVICES, INC

Monthly Rates for 2023

☐ Employee Only $8.10 ☐ Employee + Child $14.54

☐ Employee + Spouse $13.82 ☐ Employee + Family $21.37

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $130 allowance, 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Lenticular	$25 Copay	Up to $70
Standard Progressive Lens	$80 Copay	Up to $50
Premium Progressive Lens[Δ]	$110 Copay - $200 Copay	Up to $50
Tier 1	$110 Copay	Up to $50
Tier 2	$120 Copay	Up to $50
Tier 3	$135 Copay	Up to $50
Tier 4	$200 Copay	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$0	Up to $32
Standard Anti-Reflective Coating	$45	Up to $5
Premium Anti-Reflective Coating[Δ]	$57 - $85	Up to $5
Tier 1	$57	Up to $5
Tier 2	$68	Up to $5
Tier 3	$85	Up to $5
Photochromic/Transitions	$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $130
Disposable	$0 copay, $130 allowance, plus balance over $130	Up to $130
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 12 months	

QL-0000068387

[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

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*: EASI

Effective Date*^: 01 / 01 / 2023

^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.

ENROLLMENT PERIOD/PLAN YEAR: JANUARY 1, 2023 THROUGH DECEMBER 31, 2023

FLEXIBLE SPENDING PLAN ELECTION

EMPLOYER NAME: _____

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 2024 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 $2,850 for the 2023 Plan Year)* $_____

Dependent Child Care Expenses *(Not to exceed $5,000 for the 2023 Plan Year)* $ _____

Employee Signature: _____ Date:_____

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

Total number of pay periods remaining in 2023 (12, 24 or 48)

Divide the Total Annual Eligible Expenses amount by the number of pay periods in 2022 to get your pay period election.

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

$ 2 0 2 3 *(Deducted per period/Dependent care)*

Enrollment 2022-2023

Colonial Life can enroll your group in person or virtually on the phone or video call

WellVia Telemedicine

Offered FREE to each employee for NEW groups **$2.50/month for existing Colonial Groups**

Have a doctor's office visit over the phone 24 hours a day/365 days a year – use it for your family members, too! Stay at home, talk to a physician, get prescriptions for minor illnesses

WELLVIA

Commonly Treated Conditions:

Acid Reflux Allergies	Asthma	Bladder Infection	Bronchitis	Cold & Flu
Constipation	Diarrhea Diabetes	Fungal Infections	Gout	Headache
Heartburn	Hemorrhoids	High Blood Pressure	Infections	Nausea
Rashes	Sinus	Urinary Tract Infection	Sore Throat	And more!

Other Complimentary Services **for each employee**

LawAssure

FREE access to Wills, Power of Attorney, and more

Pharmacy and many other Medical discounts
Save 40% to 60%

We answer your questions and enroll you in these **affordable benefits, at no cost to the employer:**

- ☐ **Life Insurance** - Term Life Insurance; Whole life Insurance and Juvenile Whole Life Insurance offered – everyone needs life insurance!
- ☐ **Short Term Disability Insurance** - Sends 60% of your salary home if you can't work due to illness or injury; a must-have before a maternity leave
- ☐ **Cancer Insurance** – Because out-of-pocket costs are so high, get affordable financial protection for you and your family members
- ☐ **Critical Care** for Heart, Stroke and other major illnesses; lump sum payments help greatly with hospital costs
- ☐ **Medical Bridge Insurance** – Can cover deductibles and other out of pocket costs during a hospital stay that can financial stress you
- ☐ **Accident Insurance** – On/off the job, a comprehensive plan for you and the whole family

Your healthcare is PERSONAL and we want you to be SAFE

Each employee gets a one-on-one session on the telephone or a safe face-to-face with a licensed benefits counselor to answer questions and explain how WellVia Telemedicine and other benefits work for you and your family.

Colonial Life A Voluntary Benefits Partner of EASI

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

Call or email People Lease at **601-987-3029** or **info@itseasipayroll.com** to set up an Enrollment Planning Session now.

Employer name: _____

Employee Name: _____

Employee Email: _____

Employee Phone: _____

Aflac Enroll Now

Enrolling by phone is NOW available for your convenience!

Adam Sanders Employee Benefits Consultant for Aflac at
The Sanders Group Inc 601.991.1115
(Email) adam@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 EASI.

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 Adam at 601.991.1012

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.

Adam Sanders~ The Sanders Group, Inc

Remember enrolling by phone is Now an Option! 601.991.1115

EASI
EMPLOYEE ADMINISTRATIVE SERVICES, INC