



Symetra Select Benefits

Symetra Select Benefits provides valuable supplemental life and health insurance coverage for you and your eligible family members. Select Benefits can also be a valuable supplement to any major medical plan you or your dependents may already have. **Please note — Select Benefits is not a replacement for a major medical policy.**

Plan Features

- No deductibles or Co-Pays for medical benefits (some optional benefits may contain deductibles and co-pays)
- No limitations on pre-existing conditions
- No Network limitations (i.e., no PPOs or HMOs)
- No additional charge for dependents in most cases

Advantages to the Client

- No minimum number required to participate
- Attractive rates which cover the employee and any number of dependents
- A small contribution required by the Client versus the minimum of 50% requirement for major medical plans
- Most employees can afford this coverage with great coverage in all areas
- Can offer your employees peace of mind for important emergencies to the hospital and routine doctors visits (however, it does not cover major medical expenses)
- Enrollment is completely voluntary

Attached is a plan matrix to compare all three plans and the rate applicable to each plan. Applications must be completed in full and returned to the Simple HR Benefits Department at least 30 days prior to the date the coverage will be effective (always to the 1st day of the following month). More in-depth information is available **upon request.**

Should you have any questions concerning this benefit, please contact the Benefits Department at 850-650-9935, extension 37.

NOTE: The original benefit applications **MUST** be completed, signed, dated, and returned to Simple HR.

**ENROLLMENT
FORM**

Mail or Fax to:
Simple HR
P.O. Box 726
Destin, FL 32540-0726
Fax: (850) 650-9936

PART I – TO BE COMPLETED BY THE EMPLOYEE

Employee's Name (Last, First, Middle)		Social Security #	Date of Birth / /	Case Number 84750 <input type="checkbox"/> 84760 <input type="checkbox"/> 84770 <input type="checkbox"/>
Employee's Home Address		City	State	Zip Code
Employer's Name Pyramid Diversified Services		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Employment / /	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Legally Separated				
Do you have an eligible spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of eligible Children:	Indicate eligible dependents you wish to insure: <input type="checkbox"/> None <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse & Children		

DEPENDENT INFORMATION – Complete If You Are Requesting Family Coverage

No person can be insured under this policy as both an Employee and a dependent, or as a dependent of more than one Employee. Please complete the following information for each family member you wish to cover.

Dependents Name (Last, First, Middle)	Sex	Date of Birth	Relationship to Employee	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

BENEFICIARY DESIGNATION

PRIMARY (P) – The person(s) you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

CONTINGENT (C) - The person(s) you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

NOTE: The Group Policyholder may not be named as a Beneficiary.

BENEFICIARY DESIGNATION

Full Name & Address	Date of Birth	Relationship	Primary (P) Contingent (C)	% of Benefit

This Is Important – Please Read

A new Enrollment Form must be completed for any changes such as name change, beneficiary change, birth of a child, adoption of a child. The new form must be **dated, signed, and attached** to your original Enrollment Form.

This Election for Coverage Cannot Be Processed Unless All Questions Are Answered And The Form Is Signed And Dated.

DECLINATION OF INSURANCE

I have been given the opportunity to elect the Group Insurance Benefits as provided under a plan of Group Insurance established by my Employer. I have decided **NOT** to elect this coverage. I understand that if I decide to elect this insurance at a later date, satisfactory proof of insurability will be required at my expense.

Employee Signature

Date Signed

YES, I DO WANT THIS COVERAGE.

- I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company.
- I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance. **(Not applicable if the Employer pays 100% of the required contribution).**
- I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.
- All information submitted by me on this form at Symetra Life Insurance Company's request, to the best of my knowledge and belief, is true and complete.

Employee Signature

Date Signed

PART II – TO BE FILLED OUT BY THE EMPLOYER.

New Employee Late Entrant Enrollee Open Enrollment

Change Requests – Effective Date of Change ____/____/____ Effective Date of Coverage ____/____/____

Case Number 84750 84760 84770 Plan/Package Selected _____



2012 Symetra Benefits Plan Matrix

	PLAN #4 84750	PLAN #7 84760	PLAN #10 84770
LIFE INSURANCE / AD&D BENEFIT			
Life Insurance Benefit	\$5,000.00	\$10,000.00	\$20,000.00
AD&D	\$5,000.00	\$10,000.00	\$20,000.00
DEPENDENT LIFE INSURANCE BENEFIT			
Spouse	\$2,500.00	\$5,000.00	\$7,500.00
Child (6 months - 19 years / 26 if full-time student)	\$1,250.00	\$2,500.00	\$3,750.00
Infant (14 days - 6 months)	\$200.00	\$400.00	\$600.00
HOSPITAL INDEMNITY BENEFIT			
Per Day, Per Person; 30 days maximum per calendar year	\$200.00	\$500.00	\$500.00
Per Day, Per Person for treatment of alcoholism or drug abuse; 30 days maximum per calendar year	\$200.00	\$500.00	\$500.00
Per Day, Per Person for ICU; 30 days maximum per calendar year	\$400.00	\$1,000.00	\$1,000.00
Per Day, Per Person for mental illness; 30 days maximum per calendar year, 180 days per lifetime	\$100.00	\$250.00	\$250.00
Per Day, Per Person for stays in a skilled nursing facility (only if following a covered hospital stay of at least three consecutive days and the person is less than age 65); maximum 60 consecutive days per stay	\$100.00	\$250.00	\$250.00
Maximum days lifetime benefit per person (except for mental illness)	500	500	500
Benefits become payable on the first day of coverage confinement	✓	✓	✓
Maternity Care covered as any other illness	✓	✓	✓
No Deductible and no Co-payment	✓	✓	✓
No additional premium charge for additional eligible dependents	✓	✓	✓
SURGICAL BENEFIT			
Surgical Benefit per person, per calendar year maximum. Benefits paid directly to the physician/surgeon, not to the facility. No deductible and no additional premium charge for eligible dependents.	NONE	\$1,000.00	\$1,000.00
DOCTOR'S OFFICE VISIT INDEMNITY BENEFIT			
Selected dollar benefit per person, per visit up to a calendar year maximum. No deductible. Excludes routine exams and injections. No additional premium charge for eligible dependents.	\$40/\$300	\$55/\$300	\$55/\$300
OUTPATIENT DIAGNOSTIC X-RAY AND LAB (DXL) INDEMNITY BENEFIT			
Tests ordered or performed by a doctor, payable at selected dollar benefit per person, per visit up to a calendar year maximum when hospital confinement is not required. Must be medically necessary. No deductible. No additional premium charge for eligible dependents.	\$45/\$300	\$55/\$300	\$55/\$300
ADDITIONAL ACCIDENT BENEFIT			
Covered charges payable for services furnished by a doctor or hospital within 90 days after an accident. No deductible or co-payment. No additional premium for eligible dependents. Per Person, Per Calendar Year Maximum.	\$300.00	\$500.00	\$500.00
PRESCRIPTION DRUG BENEFIT			
Per person calendar year maximum, per family calendar year maximum; Co-Payment: Generic- \$10 Name Brand- \$20	NONE	NONE	\$150 / \$300
PREVENTIVE CARE INDEMNITY BENEFIT			
Routine exams, medical treatment and injections payable at selected dollar benefit per visit, up to a calendar year maximum.	NONE	\$50 / \$150	\$75 / \$150
OTHER ADDITIONAL BENEFITS			
Survivor Benefit	✓	✓	✓
Pharmacy Discount Program	✓	✓	✓
Vision Benefit	No	No	✓
Dental Care Benefit	No	No	✓
Employee Disability Weekly Benefit	No	No	✓
COBRA Eligible (Plan is portable)	✓	✓	✓
RATES:	call for pricing		