Keystaff, Inc.

Enrollment Form

Administrative Office:
Boon Administrative Services
6300 Bridgepoint Parkway,
Bldg. 3, Suite 200
Austin, TX 78730

Instructions: Complete the Enrollment Form and return to your employer's HR Department

Check the box next to the action you wish to take:

- ☐ I am not currently enrolled and wish to enroll in the coverage choices elected below.
- ☐ I am not currently enrolled and wish to waive all coverage - Must complete separate waiver form
- ☐ I am currently enrolled and wish to: ☐ Update my personal information ☐ Update my dependent/beneficiary information
- ☐ I have experienced a Qualifying Life Event (QLE): Date ____ I wish to: ☐ Elect new coverage ☐ Add/Remove Dependents ☐ Waive current coverage

Please fill out all applicable information below:

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security Number	Date of Birth	Date of Marriage
Spouse* (Last, First, M.I.)	☐ Male ☐ Female	Social Security Number	Date of Birth	

Email Address	Home/Cell Phone (include Area Code)	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No
Date of Hire	Salary	
Home Address		
City	State	Zip Code

*Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction.

Name of Child(ren)	Social Security Number	Date of Birth	
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

Beneficiary Information

Primary Beneficiary (Last, First, M.I.)	Social Security Number	Relationship
Contingent Beneficiary (Last, First, M.I.)	Social Security Number	Relationship

Employee will be the beneficiary for any dependent coverage

Choose Your Plan Option – Rates are Weekly

SmartMEC

☐ Employee Only	$10.46
☐ Employee + Spouse	$25.66
☐ Employee + Child(ren)	$34.38
☐ Employee + Family	$50.49

SmartMVP Silver

Hourly Pay Rate:	$8.00 - $11.99	$12.00 - $13.99	$14.00+
Employee Only	☐ $23.80	☐ $34.58	☐ $40.35
Employee + Spouse	☐ $145.05	☐ $155.83	☐ $161.60
Employee + Child(ren)	☐ $106.80	☐ $117.58	☐ $123.35
Employee + Family	☐ $199.86	☐ $210.64	☐ $216.41

Any changes made to the Enrollment Form will require the changes to be dated and initialed by the Applicant

Fraud Warning

CA	I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.
AL, DC, LA, NM, & RI	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
FL	I understand that 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.
KS	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 may be guilty of insurance fraud as determined by a court of law.
KY	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.
MA, NC, & OR	I understand that 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, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.
MD	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
NJ	I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
OK	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
TN & WA	It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
VA	I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.
VT	I understand that 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, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.
ME & all other states	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 subjects such person to criminal and civil penalties.

Statements and Agreements

I have read or had read to me the completed enrollment form. **I represent** (*Residents of MN and VA*: **I certify**) that all statements and answers made on or attached to this enrollment form are true to the best of my knowledge and belief. I realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate.

I have read the Fraud Warning for my state shown below.

I understand that completion of this enrollment form in no way implies that I will be accepted for insurance coverage. I understand that coverage will take effect only if this enrollment form is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate.

The policy/certificate provides limited benefits. Review your policy/certificate carefully.

Employee Signature	Date

Spouse's Signature (if applicable)

Keystaff Inc.
Waiver Form

Administrative Office:
Boon Administrative Services
6300 Bridgepoint Parkway,
Bldg. 3, Suite 200
Austin, TX 78730

To Waive Coverage: Please fill out this form for underwriting purposes

Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth

Home Address

City	State	Zip Code

Company Jobsite Locaton	Date of Hire

I am waiving coverage due to

☐ **Coverage under my parent's plan or spouse/domestic partner's plan:**

Name of Carrier	Policy ID Number

☐ **Other Coverage:**

☐ Individual Plan	☐ COBRA	☐ Tricare
☐ Medicare	☐ Medicaid	☐ Employer - Sponsored Group Plan

Name of Carrier	Policy ID Number

For the plan year effective: 12/31/2021

Proof of other coverage

Please make a copy of the front and back of your current insurance identification card and attach the copy to this form for verification purposes. Your name must be visible on the card; otherwise a letter from the insurance provider is required confirming you are a covered individual. **Proof of coverage is required**.

Please review, initial, and sign to waive coverage

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependent(s) (if any), through my employer. I understand that I am declining enrollment for myself or my eligible dependent(s) (if any) as indicated above. I also understand that I may be able to enroll myself and my eligible dependent(s) (if any) in this plan if I lose, or my eligible dependent(s) lose, eligibility for other coverage that is currently in effect.	Initial
I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.	Initial
In addition, I understand that if I have a newly eligible dependent as a result of a marriage, birth, adoption, or placement for adoption (a Qualified Life Event or QLE), I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days from the aforementioned QLE.	Initial

Employee Signature	Date

Submit the completed waiver form by one of the following methods

Submit the form to your HR Department