# Matrix ERISA Plan

**Enrollment Form**

**You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.**

## SECTION A – INFORMATION ABOUT YOU

Social Security Number | First Name | Middle Initial | Last Name

Mailing Address: Street | City

State | Zip | Home Phone Number | Birth Date: Month | Day | Year | Sex: ☐ M ☐ F

MATRIX EMPLOYEE | Name of Employer | Work Phone Number

## SECTION B – ENROLLMENT SELECTION

It is important that you follow the directions when making your elections; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section C; otherwise, their enrollment may be delayed. Costs listed below are payroll deduction amounts.

**Make your selection by putting an [X] in the box next to the selection you want. Note: You must mark a box in each section.**

### Medical Plans

**(List Dependents on back)** — Choose only ONE plan

| | | PLAN A | | | PLAN B | | |
|---|---|---|---|---|---|---|---|
| | | Weekly | Bi-Weekly | Semi-monthly | Weekly | Bi-Weekly | Semi-monthly |
| Employee Only | ☐ | $22.38 | $44.76 | $48.49 | $31.96 | $63.92 | $69.25 |
| Employee + Spouse | ☐ | $47.21 | $94.42 | $102.29 | $67.43 | $134.86 | $146.10 |
| Employee + One Child | ☐ | $33.56 | $67.12 | $72.71 | $47.94 | $95.88 | $103.87 |
| Employee + Children | ☐ | $56.61 | $113.22 | $122.66 | $80.85 | $161.70 | $175.18 |
| Employee + Family | ☐ | $75.18 | $150.36 | $162.89 | $107.38 | $214.76 | $232.66 |
| None | ☐ | | | | | | |

### Dental Plan

**(List Dependents on back)**

| | | Weekly | Bi-Weekly | Semi-monthly |
|---|---|---|---|---|
| Employee Only | ☐ | $4.45 | $8.90 | $9.64 |
| Employee + Family | ☐ | $12.75 | $25.50 | $27.63 |
| None | ☐ | | | |

### Term Life/STD Plans*

**(List Dependents on back)**

| | | Weekly | Bi-Weekly | Semi-monthly |
|---|---|---|---|---|
| Employee Only | ☐ | $5.00 | $10.00 | $10.83 |
| Employee + Family | ☐ | $5.40 | $10.80 | $11.70 |
| None | ☐ | | | |

*STD Coverage is only available for employees (no dependent coverage) and is not available for employees who work in CA, HI, NJ, NY, RI or Puerto Rico. The weekly costs for Term Life only are: $1.50 for Yourself Only or $1.90 for Yourself and Family coverage. The bi- weekly costs for Term Life only are: $3.00 for Yourself Only or $3.80 for Yourself and Family coverage. The semi-monthly costs for Term Life only are: $3.25 for Yourself Only or $4.12 for Yourself and Family coverage.

I wish to participate in the benefit plan(s) that I've selected above and I authorize my employer to deduct the required costs from my paycheck. I understand and agree that any Term Life Plan benefits payable upon my death will be paid in equal shares to members of the first surviving beneficiary class, as follows: spouse; children; parents; brothers and sisters; or, if none, then my estate.

Your Signature

Today's Date: Month | Day | Year

(OVER PLEASE)

# SECTION C – WHICH DEPENDENTS WILL BE COVERED?

**1.** First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ Medical ☐ Dental ☐ Term Life

Birth Date: Month Day Year

Social Security Number: - -

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

**Check the box here ☐ if living at a different address and list below.**

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**2.** First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ Medical ☐ Dental ☐ Term Life

Birth Date: Month Day Year

Social Security Number: - -

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

**Check the box here ☐ if living at a different address and list below.**

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**3.** First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ Medical ☐ Dental ☐ Term Life

Birth Date: Month Day Year

Social Security Number: - -

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

**Check the box here ☐ if living at a different address and list below.**

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**4.** First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ Medical ☐ Dental ☐ Term Life

Birth Date: Month Day Year

Social Security Number: - -

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

**Check the box here ☐ if living at a different address and list below.**

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## Address of Dependent not living with you:

First Name | Middle Initial | Last Name

Mailing Address: Street | City | State | Zip

If you have additional dependents or addresses for those dependents not living with you, please record all requested information on a separate sheet and attach it to this form.

There may be events that will allow you to enroll yourself and your eligible dependents outside of the Open Enrollment Periods. Please ask your employer for a Life Event Change Form which must be used for additions or changes to benefits (including Special Enrollments), outside of an Open Enrollment Period.

Medical, Dental, Term Life and Short-Term Disability Plans
underwritten by Reliance Standard Life Insurance Company