



**RANCHO
SAN MIGUEL**
100% EMPLOYEE OWNED MARKETS

Action (Check One)

- ☐ **Base Medical Plan Enrollment**
- ☐ **Buy Up Medical Plan Enrollment**
- ☐ **Declination of Coverage** (specify and sign bottom right in **red** box)
- ☐ Change (specify change) _____
(E.g., beneficiary, add/delete dependent, address)

Official Use Only

PAQ INC. Group # 10935

Effective Date: _____

By: _____

Location: _____

Employee Enrollment/Change Form

Instructions: Please complete and sign this form. Print legibly and read all questions carefully. Incomplete information will delay enrollment.

1. Participant Information						
Last Name:	First Name:	MI:	Social Security Number:	Date of Birth:	Sex ☐ Male ☐ Female	Hire Date:
Address (Number, Street, Apt):		City, State, Zip:			Home Phone:	Work Phone:

Relationship	Last Name, First Name	SSN	Other Coverage	Sex	Birth Date
☐ Spouse	Date of Marriage/Affidavit		☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 1 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 2 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 3 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 4 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 5 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 6 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	
CHILD 7 ☐ Step Child			☐ No ☐ Yes Provider: _____	☐ M ☐ F	

Revised April 2022

PAQ, INC. 100% EMPLOYEE OWNED

over

17935 Murphy Parkway
Lathrop, CA 95330

Office 209.858.9411
Fax 209.858.1437

myfood4less.com
ranchosanmiguelmarkets.com

LIFE INSURANCE BENEFICIARY DESIGNATION

This designation applies to Life Insurance Benefits. Designations are not valid unless signed, dated and delivered to Employer during your lifetime.

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Coverage for Myself and My Dependents:

Enrollment/Changes Authorization: I understand that my enrollment for myself and any of my eligible dependents is governed by the terms of the Plan. I understand that if I do not elect coverage for myself or my dependents at this time, enrollment at a later date may be conditioned on a change in family status, job status, open enrollment, or other qualifying events and notification guidelines as established by the enrollment requirements for coverage under the Plan.

Deduction Authorization: I authorize my employer to deduct on a pre-tax basis from my earnings any necessary premiums or contributions required for coverage, if applicable. If you want to decline deductions on a pre-tax basis, you must notify Human Resources. Aflac products are deducted on a post-tax basis. I understand that changes in my contributions are allowed only under the guidelines and conditions for coverage under the Plan.

Misrepresentation: Any person who knowingly submits materially false information in an application for insurance, or a fraudulent claim for the purpose of payment of a loss or benefit may be guilty of fraud and subject to criminal and civil penalties.

Certification: I certify that the above information is accurate and true, and that it is the basis for coverage issued under the Plan. I understand that misstatements, falsifications, or omissions may result in coverage under the Plan being rescinded.

Signature _____ Date _____

Declination of Coverage for Myself and My Dependents: Declining All Coverage except Life Insurance

I certify that the available coverage have been explained to me by my employer. I have been given the chance to apply for the available coverage. I have decided not to enroll myself and/or my dependent(s). By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. I am declining because I am:

- ☐ Covered Under another group health plan
- ☐ Covered under an individual health plan
- ☐ Other (Specify) _____

Check coverage below that you are declining for you and your dependents(s)

- ☐ Medical/Dental/Vision

Signature _____ Date _____