AUTOMATIC DATA PROCESSING
INSURANCE AGENCY, INC.

SGV Perinatal Medical Group Inc

Employee Benefits Open Enrollment Guide

June 1, 2025 thru May 31, 2025.

To Employees

Welcome to the 2025 Open Enrollment Period – this is the time when you may enroll in or make changes to your current benefits offered by SGV Perinatal Medical Group. This is a good opportunity for you to consider health insurance options available to you for the upcoming year and to make the best choices for you and your family.

SGV Perinatal Medical Group Inc is committed to providing high-quality, comprehensive health care coverage for you and your family. Choosing health care benefits is one of the most important decisions you make each year. We want to help you become better informed about how the different plans work so you can select the plans that are right for your needs. The purpose of this Open Enrollment Guide is to provide you with important information about the benefits available to you and your family. It summarizes the steps you need to take to enroll for coverage. We encourage you to review this guide carefully so that you can make the right choices that fit your needs of you and your family.

Each year, SGV Perinatal Medical Group reviews its benefit offerings, as well as marketplace trends and makes changes so that they remain competitive, affordable and compliant. On the following pages is an overview of what's changing for 2025.

What You Need to Know about Open Enrollment

What is Open Enrollment?
Open enrollment is a period, typically occurring once a year, when employees of all types of businesses can make additions, changes or deletions to their elected benefits. Normally, employees can only make modifications to their benefit choices during this time or if they have experienced a qualifying event. During the open enrollment period an employer will communicate to all employees what options they have for their upcoming year benefit options. If you miss out on the open enrollment period you will not be able to make any additions, changes or deletions until the following year or a qualifying event.

A qualifying event is an event that results in the opportunity to make changes to benefits outside the open enrollment period. Qualifying events include the birth of a child, marriage, the end of employment, a reduction or increase in working hours of employee or change in marital status.

How do I enroll?
During open enrollment an employer will communicate to all employees what they need to enroll. This will be the employee's opportunity to add a dependent or take someone off the plan. Employees can change enrollment type as well at this time. For example, last year an employee covered family and this year employee only wants to cover themselves, this can be done at open enrollment. You can also take the opportunity at this time to enroll for the first time. Your Employer will include enrollment form in communications.

Am I eligible? Are my dependents?
- All employees working 32 hours per week are eligible.
- Dependent children up to the age of 26.
- Domestic partners are covered under the discretion of the employer.

What does my plan entail?
Please see comparison table enclosed for plan details.

Medical Plans

United Healthcare provider search link: www.uhc.com/find-a-doctor

Plan ID	DZEX / N93S - Platinum 25-50 /400D		DZFL / L61S - Silver 60-95/40%		DZES / N95S Gold 35-70/700 D		DZET / N95S - Gold 35-70/700D		DZG8 / P60S - Gold w/Care Cash	
Carrier Name	United Healthcare		United Healthcare		United Healthcare		United Healthcare		United Healthcare	
Plan Type	HMO		HMO		HMO		HMO		PPO	
Network Name	SignatureValue		SignatureValue Harmony		SignatureValue Harmony		SignatureValue Alliance		Select Plus	
	In	Out	In	Out	In	Out	In	Out	In	Out
Individual Deductible	$0	No Coverage	$2,400	No Coveage	$0	No Coverage	$0	No Coveage	$1,000	$2,000
Family Deductible	$0	No Coverage	$4,800	No Coveage	$0	No Coverage	$0	No Coveage	$2,000	$4,000
Individual Out of Pocket Maximum	$3,000	No Coverage	$9,200	No Coveage	$7,500	No Coverage	$7,500	No Coveage	$8,150	$16,300
Family Out of Pocket Maximum	$6,000	No Coverage	$18,400	No Coveage	$15,000	No Coverage	$15,000	No Coveage	$16,300	$32,600
PCP Copay	$25 Copay	No Coverage	$60 Copay	No Coveage	$35 Copay	No Coverage	$35 Copay	No Coveage	$30 Copay	50% After deductible
Specialist Copay	$50 Copay	No Coverage	$95 Copay	No Coveage	$70 Copay	No Coverage	$70 Copay	No Coveage	$60 Copay	50% After deductible
Diagnostic test (X-ray, blood work)	$150 Copay/test	No Coverage	$45 Copay	No Coveage	$40 Copay	No Coverage	$40 Copay	No Coveage	20% After deductible	50% After deductible
Imaging (CT/PET scans, MRIs)	$150 Copay/test	No Coverage	$400 Copay	No Coveage	$300 Copay	No Coverage	$300 Copay	No Coveage	20% After deductible	50% After deductible
Urgent Care Copay	$25 Copay	No Coverage	$60 Copay	No Coveage	$35 Copay	No Coverage	$35 Copay	No Coveage	$50 Copay	50% After deductible
Emergency Room	$400 Copay	$400 Copay	40% After deductible	40% After deductible	$500 Copay	$500 Copay	$500 Copay	$500 Copay	20% After deductible	20% After deductible
Inpatient Hospitalization	$400 Copay	No Coverage	40% After deductible	No Coveage	$700 Copay	No Coverage	$700 Copay	No Coveage	20% After deductible	50% After deductible
Outpatient Surgery	$250 Copay /admi	No Coverage	40% After deductible	No Coveage	$500 Copay	No Coverage	$500 Copay	No Coveage	40% After Deductible	50% After deductible
Prescription	$5 / $30/$60/$25 up to $250	No Coverage	$20/$80/$125/$25% up to $250	No Coveage	$15 /$50 / $100 / $25% up to $250	No Coverage	$15 /$50 /$100 /$25% up to $250	No Coveage	$15 /$50 /$100/$25% Up tp $250	
RX deductible			$400 Ind / $800 Fam (Tier 2 -4)						$300 Ind /$600 Fam (Tier -2 -4)	

San Gabriel Valley Perinatal Medical Group

Monthly Medical Rates Table by Age

S 60-95/40%/2400ded DZ-FL - Harmony HMO

Zip: 91790 - County: LOS ANGELES - Rating Area: 15

Age	Rates ①
0-14	$213.29
15	$232.25
16	$239.50
17	$246.75
18	$254.55
19	$262.36
20	$270.45
21	$278.81
22	$278.81
23	$278.81
24	$278.81
25	$279.93
26	$285.50
27	$292.19
28	$303.07
29	$311.99
30	$316.45
31	$323.14
32	$329.83
33	$334.01
34	$338.48
35	$340.71
36	$342.94
37	$345.17
38	$347.40
39	$351.86
40	$356.32

Age	Rates ①
41	$363.01
42	$369.42
43	$378.35
44	$389.50
45	$402.60
46	$418.22
47	$435.78
48	$455.85
49	$475.65
50	$497.95
51	$519.98
52	$544.24
53	$568.77
54	$595.26
55	$621.75
56	$650.46
57	$679.46
58	$710.41
59	$725.74
60	$756.69
61	$783.46
62	$801.02
63	$823.05
64-99	$836.43

San Gabriel Valley Perinatal Medical Group

Monthly Medical Rates Table by Age

G 35-70/700d DZ-ET - Alliance HMO

Zip: 91790 - County: LOS ANGELES - Rating Area: 15

Age	Rates ①
0-14	$272.99
15	$297.26
16	$306.53
17	$315.81
18	$325.80
19	$335.80
20	$346.14
21	$356.85
22	$356.85
23	$356.85
24	$356.85
25	$358.28
26	$365.41
27	$373.98
28	$387.90
29	$399.32
30	$405.02
31	$413.59
32	$422.15
33	$427.51
34	$433.22
35	$436.07
36	$438.93
37	$441.78
38	$444.64
39	$450.34
40	$456.05

Age	Rates ①
41	$464.62
42	$472.83
43	$484.25
44	$498.52
45	$515.29
46	$535.28
47	$557.76
48	$583.45
49	$608.79
50	$637.33
51	$665.53
52	$696.57
53	$727.97
54	$761.87
55	$795.78
56	$832.53
57	$869.64
58	$909.25
59	$928.88
60	$968.49
61	$1,002.75
62	$1,025.23
63	$1,053.42
64-99	$1,070.55

San Gabriel Valley Perinatal Medical Group

Monthly Medical Rates Table by Age

United Healthcare

G 30/1000/20% DZ-G8 - Select Plus PPO

Zip: 91790 - County: LOS ANGELES - Rating Area: 15

Age	Rates ①
0-14	$355.48
15	$387.08
16	$399.16
17	$411.24
18	$424.25
19	$437.26
20	$450.74
21	$464.68
22	$464.68
23	$464.68
24	$464.68
25	$466.54
26	$475.83
27	$486.98
28	$505.11
29	$519.98
30	$527.41
31	$538.56
32	$549.72
33	$556.69
34	$564.12
35	$567.84
36	$571.56
37	$575.27
38	$578.99
39	$586.43
40	$593.86

Age	Rates ①
41	$605.01
42	$615.70
43	$630.57
44	$649.16
45	$671.00
46	$697.02
47	$726.29
48	$759.75
49	$792.74
50	$829.92
51	$866.63
52	$907.06
53	$947.95
54	$992.09
55	$1,036.24
56	$1,084.10
57	$1,132.43
58	$1,184.00
59	$1,209.56
60	$1,261.14
61	$1,305.75
62	$1,335.03
63	$1,371.74
64-99	$1,394.04

San Gabriel Valley Perinatal Medical Group

Monthly Medical Rates Table by Age

G 35-70/700d DZ-ES - Harmony HMO

Zip: 91790 - County: LOS ANGELES - Rating Area: 15

Age	Rates ①
0-14	$256.68
15	$279.50
16	$288.22
17	$296.94
18	$306.34
19	$315.73
20	$325.46
21	$335.53
22	$335.53
23	$335.53
24	$335.53
25	$336.87
26	$343.58
27	$351.64
28	$364.72
29	$375.46
30	$380.83
31	$388.88
32	$396.93
33	$401.96
34	$407.33
35	$410.02
36	$412.70
37	$415.39
38	$418.07
39	$423.44
40	$428.81

Age	Rates ①
41	$436.86
42	$444.58
43	$455.31
44	$468.74
45	$484.51
46	$503.30
47	$524.43
48	$548.59
49	$572.41
50	$599.26
51	$625.76
52	$654.95
53	$684.48
54	$716.36
55	$748.23
56	$782.79
57	$817.69
58	$854.93
59	$873.38
60	$910.63
61	$942.84
62	$963.98
63	$990.48
64-99	$1,006.59

San Gabriel Valley Perinatal Medical Group

Monthly Medical Rates Table by Age

United Healthcare

P 25-50/400d DZ-EX - Signature HMO

Zip: 91790 - County: LOS ANGELES - Rating Area: 15

Age	Rates ①
0-14	$342.57
15	$373.02
16	$384.66
17	$396.30
18	$408.84
19	$421.38
20	$434.37
21	$447.80
22	$447.80
23	$447.80
24	$447.80
25	$449.59
26	$458.55
27	$469.29
28	$486.76
29	$501.09
30	$508.25
31	$519.00
32	$529.75
33	$536.46
34	$543.63
35	$547.21
36	$550.79
37	$554.38
38	$557.96
39	$565.12
40	$572.29

Age	Rates ①
41	$583.04
42	$593.34
43	$607.66
44	$625.58
45	$646.62
46	$671.70
47	$699.91
48	$732.15
49	$763.95
50	$799.77
51	$835.15
52	$874.11
53	$913.51
54	$956.05
55	$998.59
56	$1,044.72
57	$1,091.29
58	$1,140.99
59	$1,165.62
60	$1,215.33
61	$1,258.32
62	$1,286.53
63	$1,321.91
64-99	$1,343.40

DENTAL PLAN	Sunlife		Sunlife	
	Dental PPO		PLUS Plan	
Network	Sunlife Dental Network			
Beneift	In Network	Out of Network	In Network	Out Network
Claim Basis payment		90th		
Deductible	$50 Ind / $150 Fam		None	
Period	Calender year		Calender year	
Preventive Services	100% (Deductible does not apply)		Copay	
Type 1 - Basic Services	80%		Copay	
Type 2 - Major Services	50%		Copay	
Type III -Ortho Services	50%		Copay	
Annual Maximum	$2000 per person		Copay	
Ortho Lifetime Maximum	$1500 per child under age 26		Copay	
	Rates (Does not include Employer contribution)			
Employee Only	$55.91		$13.40	
Empl + Spouse	$105.57		$24.00	
Empl+ Child(ren)	$106.85		$33.27	
Empl+ Family	$176.83		$39.28	

Vision Plan	**Sunlife**	
Network	VSP	
Eye Exams	Calender Year	
Lenses Benefits	Calender Year	
Contact Lenses	Calender Year	
Frames	Other Year	
	In Network	Out of Network
Vision Exam	$10	$45 Allowance
Lenses Benefits		
Single Vision	$15 Copay	$30 Allowance
Bifocal	$15 Copay	$50 Allowance
Trifocal	$15 Copay	$60 Allowance
Lenticular	$15 Copay	$100 Allowance
Contact Lenses		
Medically Necessary	$15 Copay	$210 Allowance
Elective Contact Lenses	$60 Allowance 15% savings for contact exam.	$105 Allowance
Frames	$200 for frame. 20% off the amount over the allowance at Cosco	$70 Allowance
Laser Vision Correction Discount	* Average 15% of the regular price or 5% off the promotional prices. *Discount only available form contracted facilities.	N/A
	Rates (Employer Contribution not included)	
Employee Only	$9.32	
Empl + Spouse	$18.64	
Empl+ Child(ren)	$19.96	
Empl+ Family	$31.90	

Basic Life / AD&D	Sunlife	
Guarantee Issue	$220,000	
Maximum Benefit	$400,000	
Volume	$40,000	
Per $1000 of Volume	Per $1000 of Volume	
Life	0.122	
AD&D	0.024	
nployee Benefit Reductic	Age	Reduction
	70	50%
	65	65%

Voluntary Life / AD&D	Employee		Spouse		Children (up to age 26)	
	Increments of $10,000		Increments of $5,000		Increments of $1,000	
Guarantee Issue	$100,000		$25,000		Any amount	
Maximum Benefit	Lesser of: $500,000 or 5 Times your Basic Earnings		$100,000		$10,000	
Per $1000 of Volume	Per $1000 of Volume		Per $1000 of Volume		Per $1000 of Volume	
Life	Rates on next page		Rates on next page		Rates on next page	
AD&D	Rates on next page		Rates on next page		Rates on next page	
Employee Benefit Reduction	Age	Reduction	Age	Reduction		
	70	50%	70	50%		
	65	65%	65	65%		

Employee Voluntary Life

Age band	Monthly rate
Under age 20	$0.041
20-24	$0.041
25-29	$0.041
30-34	$0.041
35-39	$0.062
40-44	$0.095
45-49	$0.153
50-54	$0.216
55-59	$0.338
60-64	$0.515
65-69	$0.828
70-74	$1.547
75-79	$3.377
80-84	$6.968
85 and over	$14.615

Rate basis: Per $1,000 of vol

Spouse Voluntary Life

Age band	Monthly rate
Under age 20	$0.129
20-24	$0.129
25-29	$0.129
30-34	$0.129
35-39	$0.166
40-44	$0.239
45-49	$0.392
50-54	$0.572
55-59	$0.908
60-64	$1.395
65-69	$2.095
70-74	$4.213
75-79	$9.133
80-84	$18.239
85 and over	$36.135

Rate basis: Per $1,000 of vol

Child Voluntary Life	$0.329

Rate basis: Per $1,000 of vol

Long Term Disability

Carrier	Sunlife
Elimination Periold	180 Days
Monthly Benefit Amount	60% of your Total Monthly Earnings
Maximum Benefit	$15,000
Minimum Benefits	$100
Rate per $100	Monthly Rates w/o Employer Contributions
Class 1	$0.949
Class 2	$0.207
Maximum Benefit Duration	See Chart below

Age at Disability	Maximum Benefit Duration
Less than age 63	To age 65, but not less than 48 Months
63	48 Months
64	36 Months
65	30 Months
66	27 Months
67	24 Months
68	21 Months
69 and over	18 Months

Year of Birth	Normal Retirement Age
Before 1938	Age 65
1938	Age 65 and 2 Months
1939	Age 65 and 4 Months
1940	Age 65 and 6 Months
1941	Age 65 and 8 Months
1942	Age 65 and 10 Months
1943 through 1954	Age 66
1955	Age 66 and 2 Months

(DO NOT STAPLE)

California
Small Business
Employee Enrollment Form

To speed the enrollment process, please be thorough and fill out all sections that apply.

United Healthcare

UnitedHealthcare Insurance Company
UnitedHealthcare of California
UnitedHealthcare Benefits Plan of California

To Be Completed by Employer	Group Name/Number	
Requested Effective Date of Insurance / Health Plan Coverage / Date of Change / /	Reason for Application ☒ New Group Plan ☐ New Hire ☐ Dependent Add/Delete ☐ Annual Open Enrollment ☐ Change Name/Address ☐ Late Enrollee ☐ Termination Date: / / ☐ Waiving Coverage (Complete Sections A and E) ☐ Life Event/Date ☐ Status Change ☐ Other	Employee Type (check all that apply) ☐ Active ☐ Union ☐ Non-Union ☐ Retired ☐ Hourly ☐ Salary ☐ Other ☐ COBRA ☐ Cal-COBRA Start Date / / End Date / Indicate Qualifying Event Original Qualifying Event Date Start Date / / End Date / /
Date of Hire 07 / 01 / 2024		
Position/Title Physician		
Hours Worked Per Week 40		

A. Employee Information	**Complete All Sections** **If you are waiving coverage, please complete only Sections A and E**

Last Name	First Name	MI	Social Security Number	Home Phone
Licon	Ernesto		639106732	

Address	Apt	City	State	ZIP Code	Cell Phone
3360 E. Foothill Blvd	#13	Pasadena	CA	91107	9157314713

Date of Birth	Sex	Marital Status	Have you or your dependents ever been a UnitedHealthcare member?
12 / 07 / 1988	☒ F ☐ M ☐ U	☐ Single ☒ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner	☐ Yes ☒ No

Preferred Language: ☒ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other

Race/Ethnicity – Check all that apply[1] ☒ Prefer not to answer ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

ZIP Code: 91107

E-mail address: ernestolicon@gmail.com

To select paperless delivery complete and sign the enrollment form and provide your email address. Check here to receive your Required Plan Communications by mail ☒

Primary Care Physician[2] Name:
Address:
ID# Existing Patient Medical ☐ Yes ☐ No

Primary Care Dentist[3] Name:
ID#:
Existing Patient Dental ☐ Yes ☐ No

Coverage provided by "UnitedHealthcare and Affiliates":
Check appropriate box(s) for coverage(s) selected:
Medical ☐ UnitedHealthcare Insurance Company or ☐ UnitedHealthcare Benefits Plan of California (Insurance Products: Navigate, Select Plus, Core, Doctors Plan, Non-Diff)
Medical ☒ UnitedHealthcare of California (HMO)
Dental ☒ UnitedHealthcare Benefits Plan of California or ☐ UnitedHealthcare Insurance Company or ☐ Dental Benefit Providers of California, Inc.
Vision ☒ UnitedHealthcare Benefits Plan of California or ☐ UnitedHealthcare Insurance Company
Administrative services provided by United Healthcare Services, Inc. Optum Rx Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

IMPORTANT: (1) Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination. (2) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (3) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (4) For court-ordered dependent, legal documentation must be attached. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Subscriber Last, First Name Licon Ernesto **SSN** 639106732

C. Product Selection

Please check the box for each plan you or your dependents are enrolling in. Benefit offerings are dependent on employer selections.

Person	Medical	Dental	Vision	**Medical Plan and Dental Plan Selection** – Write in the Plan Code or Description of Medical and Dental plan in which you wish to enroll.
Employee	☒	☒	☒	Medical Plan Code/Description: DZ-ES Harmony HMO
Spouse/Domestic Partner	☒	☒	☐	
Dependents	☒	☒	☒	Dental Plan Code/Description: Sunlife Plus Plan

D. Other Medical Insurance/Health Plan Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this insurance/health plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical insurance/health plan coverage, including another UnitedHealthcare plan or Medicare?

☐ Yes (continue completing this section) ☒ No (If NO, then skip the rest of the Other Medical Insurance/Health Plan Coverage section.)

Name of other carrier _____

Other Group Medical Insurance/Health Plan Coverage Information (only list those covered by other plan)	Type (B/S/F)†	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder/ covered employee for other insurance/health plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

†B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):

Medicare – Employee/Spouse/Domestic Partner/Dependent Name: _____

Medicare ID# _____ (Please attach a copy of your Medicare ID card.)

☐ Enrolled in Part A: Effective Date ____/____/____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)

☐ Enrolled in Part B: Effective Date ____/____/____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)

☐ Enrolled in Part D: Effective Date ____/____/____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)

☐ Disabled ☐ Disabled but actively at work

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ Yes ☐ No Start Date ____/____/____

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

Complete only if you are waiving coverage for yourself and/or any family member.

I decline all coverage for:	Medical	Dental	Vision
Myself	☐	☐	☐
Spouse/Domestic Partner	☐	☐	☐
Dependent Children	☐	☐	☐
Myself and all dependents	☐	☐	☐

Declining coverage reason:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ COBRA/ Cal-COBRA

☐ California Health Benefit Exchange AB1401 from Prior Employer

☐ Covered by Medicare ☐ Medicaid ☐ Tri-Care

☐ VA Eligibility ☐ I (we) have no other coverage at this time

☐ Other _____

Employee Application

Please print clearly in blue or black ink.

ISSUE
Check one – Employer Use

☒ New Employee ☐ Change ☐ COBRA

Employee Information – *Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.*

Employee name (*last, first, initial*)	Employer	Employment location
Licon, Ernesto	San Gabriel Valley Perinatal Medical Group	

Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate
			639-10-6732	12/07/1988

Sex	Job title or position	Employee hire date	# hours per week	Earnings $ _____	Married	Children
☒ M ☐ F	Physician	07/01/2024	40	☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other _____	☒ Yes ☐ No	☒ Yes ☐ No

Address	City	State	Zip
3360 E. Foothilll Blvd #135	Pasadena	CA	91107

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

Dependent Information – ***Required if Dependent coverage applies***

Name (Last name, First Name)	Date of Birth	Gender	Relationship
Ma, Yue	03/05/1983	F	Spouse
Licon, Katherine	11/27/2014	F	Child
Licon, Anderson	09/22/2024	M	Child

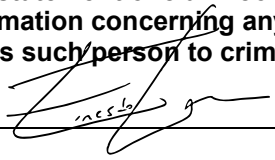
NOTE – *Coverage not elected will be assumed refused even if not specifically refused*

Benefits
You may select the benefits below.

☐ Employee Life
☐ Voluntary Life Amount Electing _____
Have you used tobacco in any form in the last 12 months? ☐ Yes ☐ No
☐ Employee AD&D
☐ Voluntary AD&D Amount Electing _____
☐ Dependent Life
☐ Voluntary Spouse Amount Electing _____
Name of Spouse _____
Date of birth _____
Has your spouse used tobacco in any form in the last 12 months? ☐ Yes ☐ No
☐ Voluntary Child ☐ $1,000 ☐ $5,000 ☐ $10,000
☐ Short Term Disability
☐ Voluntary STD Amount Electing _____
☐ Long Term Disability
☐ Voluntary LTD Amount Electing _____
☐ Dental – Employee

(8) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
(9) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

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.

Employee's signature  Date 05/14/2025

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____