BSi Companies
304 Ridgeland Dr.
Greenville, SC 29601
1(888) 298-6828 Fax (864) 467-9489

Ancillary Benefit Election

April 1, 2026– March 31, 2027

☐ **New Hire** ☐ **Change** ☐ **Remove/Add**

EMPLOYEE INFORMATION

Please **Print or Type** the following information

Last Name:	First Name:		MI:
SSN:	Date of Birth:	Married: Y / N	Sex: M / F
Address:			
City:	State:	Zip:	
Date of Hire:	Phone Number:	Job Title:	
Email Address:			

EMPLOYEE ☐ Yes **DEPENDENT(S)** ☐ Yes ☐ No

COVERAGE INFORMATION

Please check off your desired benefit elections(s). You and any elected dependent(s) will be covered on the first day of the month in which your payroll deduction starts. For example, if TDY MEDICAL STAFFING, INC. begins deducting in the payroll period starting April 1, 2026, you and any elected dependent(s) will be covered starting April 1, 2026.

VOLUNTARY BENEFITS - Vision/Dental/Life/AD&D/EAP	COST Bi-WEEKLY PAYROLL (Per Pay Check)
Self	☐ $27.24
Add Spouse	☐ $55.74
Add Child(ren)	☐ $65.09
Add Spouse +Child(ren)	☐ $101.49

DEPENDENT INFORMATION

If you are electing Self only coverage, **DO NOT FILL OUT THE REST OF THIS SECTION.** If you accept dependent coverage, be sure to complete the Wage Deduction form and submit support documentation, a marriage certificate, birth certificate or other proof of dependency.

COVERAGE ELECTION: ☐ Self ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self & Family

Spouse Name:_____ ☐ Check this box if your spouse is also employed by the company

Date of Birth:_____ SSN:_____ Sex: M / F Date of Marriage:_____

Dependent Child (ren):

Child 1 Name:_____ DOB:_____ Sex: M / F SSN: _____

Child 2 Name:_____ DOB:_____ Sex: M / F SSN: _____

Child 3 Name:_____ DOB:_____ Sex: M / F SSN: _____

If you need additional space, write the total number of additional dependents here:_____ and finish on an additional medical enrollment form.

_____ _____

Signature Date

TDY MEDICAL STAFFING, INC.
Payroll Deduction and Benefit Election Form 2026
Election Period: April 1, 2026 through March 31, 2027

BENEFICIARY INFORMATION

Please **Print or Type** the following information
Life insurance maybe designated to any person(s) or entity. It may also be divided.

Full Name	%	Address	City	State	Zip	Relationship
Primary: (First to receive)						
Contingent: (Second to receive)						

I hereby authorize my employer, TDY MEDICAL STAFFING, INC., to redirect the above portion of my salary to the TDY MEDICAL STAFFING, INC. Health and Welfare Plan for the coverage elected above. Payroll deduction will be taken pre-tax, which means coverage will remain in effect for the full plan year unless a change in life-status occurs that qualifies under Section 125 of the Internal Revenue Code as a permissible basis for discontinuing my coverage election. Deductions shall continue from year to year unless you make a change to your open enrollment or have a qualifying event.

Signature _____ Date _____