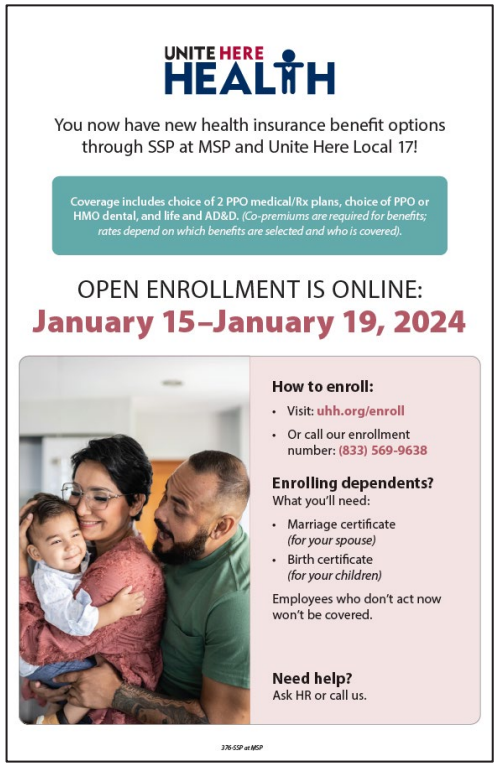
Communications Dashboard: January 2024

PRINT HIGHLIGHTS

Atlantic City BeneCare Dental

Penn Cancer Flyer

SSP at St. Paul-Minneapolis



Links to Print Pieces

Compliance

- FSP Kaiser Opt-Out Flyer

Educational

- AC BeneCare Dental
- FSP Hourly Rate Plan Mailing to OTG
- Penn Cancer Flyer

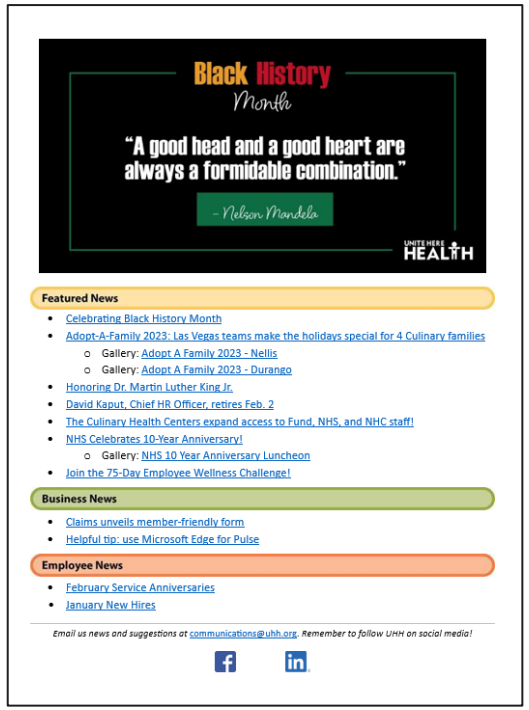
Enrollment

- 105/376 New Meadowlands
- 100/105 Annual Enrollment
- 278 Annual Enrollment
- 376 Sodexo at Camden County CC Dental
- Aramark at Hamline University
- Compass at Amex Lounge Austin
- Nationals Ballpark Dental/Vision
- Nationals Ballpark Medical
- SSP at Philadelphia Airport
- SSP at St. Paul-Minneapolis Airport

Communications Dashboard: January 2024

DIGITAL HIGHLIGHTS

Monthly Newsletter



Social Media

View previous dashboards:
uhh.org/dashboards

Links to Digital Pieces

Compliance
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Educational
- AC BeneCare Dental

Enrollment
- 376 Sodexo at Camden County CC Dental
- Aramark at Hamline University
- Compass at Amex Lounge Austin
- SSP at St. Paul-Minneapolis Airport

Email Stats

Sends
7,037

Open Rate
54%

Click Rate
3%

Opt-In Totals

Compliance
27,916

Generic Email
33,209

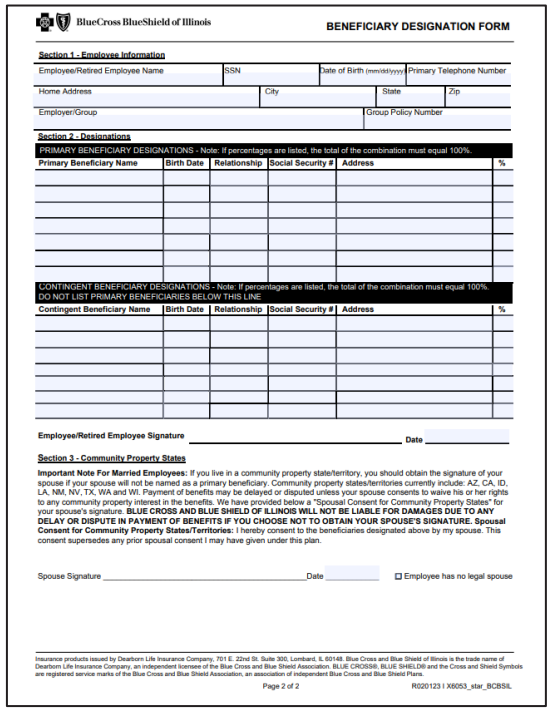
Generic Texting
36,306

Communications Dashboard: January 2024

UPDATED FORMS

Use these updated forms moving forward. Please delete any previous versions.

Life Insurance Beneficiary Form



BlueCross BlueShield of Illinois

BENEFICIARY DESIGNATION FORM

Section 1 - Employee Information

Employee/Retired Employee Name	SSN	Date of Birth (mm/dd/yyyy)	Primary Telephone Number

Home Address	City	State	Zip

Employer/Group	Group Policy Number

Section 2 - Designations

PRIMARY BENEFICIARY DESIGNATIONS - Note: If percentages are listed, the total of the combination must equal 100%.

Primary Beneficiary Name	Birth Date	Relationship	Social Security #	Address	%

CONTINGENT BENEFICIARY DESIGNATIONS - Note: If percentages are listed, the total of the combination must equal 100%. DO NOT LIST PRIMARY BENEFICIARIES BELOW THIS LINE

Contingent Beneficiary Name	Birth Date	Relationship	Social Security #	Address	%

Employee/Retired Employee Signature _____ **Date** _____

Section 3 - Community Property States

Important Note For Married Employees: If you live in a community property state/territory, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states/territories currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI. Payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. **BLUE CROSS AND BLUE SHIELD OF ILLINOIS WILL NOT BE LIABLE FOR DAMAGES DUE TO ANY DELAY OR DISPUTE IN PAYMENT OF BENEFITS IF YOU CHOOSE NOT TO OBTAIN YOUR SPOUSE'S SIGNATURE. Spousal Consent for Community Property States/Territories:** I hereby consent to the beneficiaries designated above by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature _____ Date _____ ☐ Employee has no legal spouse

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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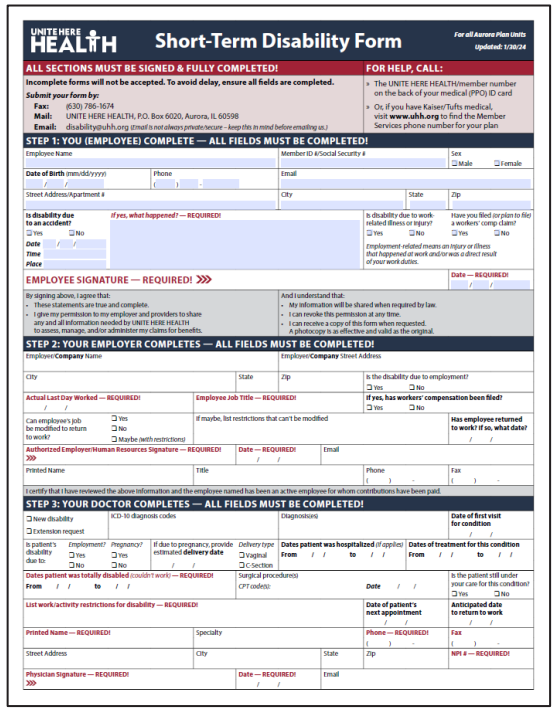
Short-Term Disability Form



UNITE HERE HEALTH

Short-Term Disability Form

For all Aurora Plan Units
Updated: 1/30/24

ALL SECTIONS MUST BE SIGNED & FULLY COMPLETED!

Incomplete forms will not be accepted. To avoid delay, ensure all fields are completed.

Submit your form by:
Fax: (630) 786-1674
Mail: UNITE HERE HEALTH, P.O. Box 6020, Aurora, IL 60598
Email: disability@uhh.org *(Email is not always private/secure - keep this in mind before emailing us.)*

FOR HELP, CALL:
- The UNITE HERE HEALTH/member number on the back of your medical (PPO) ID card
- Or, if you have Kaiser/Tufts medical, visit **www.uhh.org** to find the Member Services phone number for your plan

STEP 1: YOU (EMPLOYEE) COMPLETE — ALL FIELDS MUST BE COMPLETED!

Employee Name | Member ID #/Social Security # | Sex ☐ Male ☐ Female

Date of Birth (mm/dd/yyyy) | Phone | Email

Street Address/Apartment # | City | State | Zip

Is disability due to an accident? ☐ Yes ☐ No — If yes, what happened? — REQUIRED! — Date / Time / Place

Is disability due to work-related illness or injury? ☐ Yes ☐ No

Have you filed (or plan to file) a workers' comp claim? ☐ Yes ☐ No

Employment-related means an injury or illness that happened at work and/or was a direct result of your work duties.

EMPLOYEE SIGNATURE — REQUIRED! >>> | Date — REQUIRED!

By signing above, I agree that:
- These statements are true and complete.
- I give my permission to my employer and providers to share any and all information needed by UNITE HERE HEALTH to assess, manage, and/or administer my claims for benefits.

And I understand that:
- My information will be shared when required by law.
- I can revoke this permission at any time.
- I can receive a copy of this form when requested. A photocopy is as effective and valid as the original.

STEP 2: YOUR EMPLOYER COMPLETES — ALL FIELDS MUST BE COMPLETED!

Employer/Company Name | Employer/Company Street Address

City | State | Zip | Is the disability due to employment? ☐ Yes ☐ No

Actual Last Day Worked — REQUIRED! | Employee Job Title — REQUIRED! | If yes, has workers' compensation been filed? ☐ Yes ☐ No

Can employee's job be modified to return to work? ☐ Yes ☐ No ☐ Maybe (with restrictions) | If maybe, list restrictions that can't be modified | Has employee returned to work? If so, what date?

Authorized Employer/Human Resources Signature — REQUIRED! >>> | Date — REQUIRED! | Email

Printed Name | Title | Phone | Fax

I certify that I have reviewed the above information and the employee named has been an active employee for whom contributions have been paid.

STEP 3: YOUR DOCTOR COMPLETES — ALL FIELDS MUST BE COMPLETED!

☐ New disability ☐ Extension request | ICD-10 diagnosis codes | Diagnosis(es) | Date of first visit for condition

Is patient's disability due to: Employment? ☐ Yes ☐ No Pregnancy? ☐ Yes ☐ No | If due to pregnancy, provide estimated delivery date | Delivery type ☐ Vaginal ☐ C-Section | Dates patient was hospitalized (if applies) From / / to / / | Dates of treatment for this condition From / / to / /

Dates patient was totally disabled (couldn't work) — REQUIRED! From / / to / / | Surgical procedure(s) CPT code(s): | Date / / | Is the patient still under your care for this condition? ☐ Yes ☐ No

List work/activity restrictions for disability — REQUIRED! | Date of patient's next appointment / / | Anticipated date to return to work / /

Printed Name — REQUIRED! | Specialty | Phone — REQUIRED! | Fax

Street Address | City | State | Zip | NPI # — REQUIRED!

Physician Signature — REQUIRED! >>> | Date — REQUIRED! | Email

Links to Updated Forms

Forms

- Life Insurance Beneficiary Form
- Short-Term Disability Form