Benefit Election Form

With this form, you'll choose insurance coverage for yourself & family. If you waive (decline) medical coverage for yourself or your dependents now, you will NOT be able to get coverage until the next open enrollment period or within 31 days of a status change (e.g., death, birth, marriage, etc.) and there may be extensive waiting periods. All amounts are based on payroll frequency calculations and will be deducted from your pay.

Section 125 – Pre-tax Payroll Deduction of Premiums

Any Medical, Dental, Vision insurance premiums and HSA contributions you elect for the next plan year will be treated as pre-tax premiums according to Section 125. If you do not want them treated this way, you must contact the Human Resources Department before your effective date.

Important Information on the Section 125 – Flexible Benefit Plan

If you elect any of the Section 125 – Flexible Benefit Plan options, please read and sign the following terms and conditions. In choosing any of the Section 125 options, I understand that:

1. **I cannot change or revoke this benefit election or salary reduction** before the next plan year, unless I have a significant change in benefits or cost of coverage, or a change in status (including marriage, divorce, death of a spouse or a child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I take an unpaid leave of absence, dependent becomes eligible/ineligible for coverage due to age, a change in worksite or residence of employee, spouse, or dependent that would affect the availability or current elected benefits) or other such events as the Plan Administrator determines will permit a change or revocation of an election.

2. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my salary reduction will automatically be adjusted to reflect that increase or decrease.

3. **Before the plan year ends, I will be offered the opportunity to change my benefit election(s) for the following Plan Year.** If I **do not** complete and return a new election form at that time, my previous insured benefit choices will continue in effect for the new Plan Year **but not my non-insured benefits**. In addition, this salary reduction agreement will continue by its terms in the amount of the required contribution for the insured benefit option.

4. The Plan Administrator may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in accordance with the Section 125 – Flexible Benefit Plan if he believes it is advisable to satisfy certain provisions of the Internal Revenue code or other applicable law.

5. The reduction in my salary under this agreement is in addition to any reductions under other agreements or benefit plans maintained by my employer.

This agreement is subject to the terms of the employer's Section 125 – Flexible Benefits Plan, as amended from time to time, and shall be governed by and construed in accordance with applicable laws. This agreement revokes any prior election and salary reduction agreement relating to the Section 125 – Premium Conversion Plan.

GROUP BENEFITS ENROLLMENT FORM

FOR COMPANY USE ONLY (EFFECTIVE 1/1/2022)

Class: Semi-Monthly _____
Salary: _____
Department: _____
Effective Date: _____

REASON FOR ENROLLMENT: ☐ New Hire ☐ Open Enrollment
QUALIFYING EVENT: ☐ Loss of coverage ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ Over-age dependent ☐ Hours Reduction

COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision

STATUS CHANGE: ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination
☐ Electing COBRA (Reason for Election) _____
☐ Waiver of Coverage ☐ Other _____

PERSONAL INFORMATION

Employee's Full Name		SSN			Occupation	
Home Address		City	State		Zip Code	County
Home Phone	Work Phone	Email Address			Date of Birth	Date of Hire
Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Primary Language ☐ English ☐ Spanish ☐ Other			Hours Worked Per Week	

DEPENDENTS TO BE COVERED

Name of Person to be Covered Last First MI	SS #	Gender	Date of Birth	*Address (if different than employee)
Spouse		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		

Are you presently covered on a health insurance plan? ☐ Yes ☐ No **If yes,** how long has this coverage been continuous? _____

If yes, what type of coverage: ☐ Spouse's Coverage ☐ COBRA ☐ Present Employer's Coverage ☐ Medicare/Medicaid ☐ Other _____

Name of Present Insurance Company: _____ Name of Policy Holder: _____

Policy # or Medicare #: _____ Address of Insurance Company: _____

GROUP BENEFITS ENROLLMENT FORM

UHC MEDICAL PLAN - Cost semi-monthlyl			
☐ Waive Coverage	☐AXKY $5,000 EPO Plan	☐BC1I $3,000 EPO Plan	☐AE3M $6,350 HSA Plan
☐ Employee Only	$189.25	$260.71	$161.78
☐ Employee & Spouse	$645.61	$809.96	$582.41
☐ Employee & Child(ren)	$470.08	$598.70	$420.63
☐ Employee & Family	$926.43	$1,147.94	$841.25

BCBS DENTAL PLAN - Cost semi-monthly		VSP VISION PLAN - Cost semi-monthly	
☐ Waive Coverage		☐ Waive Coverage	
☐ Employee Only	$27.55	☐ Employee Only	$4.58
☐ Employee & Spouse	$70.65	☐ Employee & Spouse	$7.32
☐ Employee & Child(ren)	$55.11	☐ Employee & Child(ren)	$7.47
☐ Employee & Family	$108.13	☐ Employee & Family	$12.05

HSA Contribution

If 55 years of age or older, you may elect to contribute an additional $1,000 catch up contribution for 2022.

Contribution Election monthly: $ _____ $ _____ lump sum

Annual Individual Limits - $3,650 (2022) Annual Family Limits - $7,300 (2022)

IMPORTANT

I understand and have verified the benefit selections I have made and authorize any payroll deductions required for these selections. I also understand that the above selections for medical, dental, and vision (which are all pre-tax deductions) may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I understand that, by participating in any pre-tax plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. I also have read and understand the enrollment provisions, including restrictions stated on this form.

Details of each plan are contained in various insurance contracts and other legal documents. In the even of a conflict the contracts and plan documents prevail.

Compliance information located on www.insuranceisboring.com. See HR for user name and password.

Printed Name: _____ Signature: _____ Date: _____