# 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.

## REQUIRED: COMPANY USE ONLY

| *Date of Hire* | *Effective Date* | *Occupation / Title* | *Salary* | *Pay Frequency* ☐ Weekly \| ☐ Semi-Monthly ☐ Bi-Weekly \| ☐ Monthly |
|---|---|---|---|---|
| | | | | |

## ENROLLMENT/ELECTION INFORMATION

**REASON FOR ENROLLMENT:** ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event ☐ Re-Hire

**COMPANY PROVIDED INSURANCE:** ☒ Short-Term Disability ☒ Long-Term Disability ☒ Basic Life & AD&D Insurance

**ELECTIVE INSURANCE SELECTED:** ☐ Medical ☐ Dental ☐ Vision (see page 2 for selections)

**WAIVE COVERAGE:** ☐ Medical ☐ Dental ☐ Vision Reason for Declining:

**STATUS CHANGE:** ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination

## EMPLOYEE INFORMATION REQUIRED

| **Employee's Full Name (FIRST MI LAST)** | **Date of Birth** | **SS#** |
|---|---|---|
| | | |

| **Home Address** ☐ **Update address** | **City** | **State** | **Zip** | **HMO/PCP#** |
|---|---|---|---|---|
| | | | | |

| **Home Phone** | **Work Phone** | **Email Address** ☐ **Work** ☐ **Personal** |
|---|---|---|
| | | |

| **Gender** ☐ Male ☐ Female | **Marital Status** ☐ Single ☐ Married | ☐ **Tobacco** ☐ **Non-Tobacco** | **Date of Qualifying Event** |
|---|---|---|---|
| | | | |

### DEPENDENTS TO BE COVERED

| **Name of Person to be Covered** **Last First MI** | **SS #** | **Gender** | **Date of Birth** | **HMO/PCP#** |
|---|---|---|---|---|
| **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 | | |

## COMPANY-PROVIDED INSURANCE

**FEM Centre** provides eligible full-time employees Basic Life & AD&D insurance coverage of $50,000, Short-Term and Long-Term Disability.

## INSURANCE BENEFICIARY DESIGNATION (COMPLETE EVEN IF OTHER BENEFITS ARE WAIVED)

| **Primary Beneficiary Name** | **Relationship** | **Social Security Number** | **% of Assets** | **Beneficiary Address** (if different from yours) |
|---|---|---|---|---|
| | | | | |
| **Contingent Beneficiary Name** | **Relationship** | **Social Security Number** | **% of Assets** | **Beneficiary Address** (if different from yours) |
| | | | | |

| Bi-Weekly Cost | MEDICAL PLAN PPO OPTIONS | | |
|---|---|---|---|
| **Plan *(Choose One)*** | ☐ **PPO – P620CHC** | ☐ **PPO – G654CHC** | ☐ **PPO – S661CHC** |
| ☐ Waive Coverage | NA | NA | NA |
| ☐ Employee Only | $ 413.52 | $ 313.43 | $ 238.53 |
| ☐ Employee & Spouse | $1,141.88 | $ 941.71 | $ 791.91 |
| ☐ Employee & Child(ren) | $1,141.88 | $ 941.71 | $ 791.91 |
| ☐ Employee & Family | $1,870.25 | $1,570.00 | $1,345.29 |

| Bi-Weekly Cost | MEDICAL PLAN HMO OPTIONS | | | |
|---|---|---|---|---|
| | ☐ **HMO – P610ADT No Out-of-Network Coverage** | ☐ **HMO – G664ADT No Out-of-Network Coverage** | ☐ **HMO – S642ADT No Out-of-Network Coverage** | **HMO** – Must Select PCP Insert Primary Care Physician's Name & HMO Number |
| ☐ Waive Coverage | NA | NA | NA | |
| ☐ Employee Only | $ 168.29 | $ 92.17 | $ 50.01 | |
| ☐ Employee & Spouse | $ 651.42 | $ 499.20 | $ 414.87 | |
| ☐ Employee & Child(ren) | $ 651.42 | $ 499.20 | $ 414.87 | |
| ☐ Employee & Family | $1,134.56 | $ 906.23 | $ 779.73 | |
| Reason for Declining: ☐ Cost ☐ Other Coverage ☐ Other (please describe) | | | | |

| DENTAL PLAN | | |
|---|---|---|
| **Plan *(Choose One)*** | ☐ DHMO | ☐ PPO |
| ☐ Waive Coverage | NA | |
| ☐ Employee Only | $0.00 | $13.40 |
| ☐ Employee & Spouse | $4.48 | $32.91 |
| ☐ Employee & Child(ren) | $8.19 | $40.24 |
| ☐ Employee & Family | $13.08 | $59.76 |
| DHMO Provider: | | |

| VISION PLAN VSP | |
|---|---|
| ☐ Waive Coverage | NA |
| ☐ Employee Only | $0.00 |
| ☐ Employee Plus One | $6.72 |
| ☐ Employee & Family | $9.93 |

**IMPORTANT**

I understand and have verified the benefit selections I have made and authorize my employer to deduct 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 event of a conflict the contracts and plan documents prevail.

Compliance information located on www.insuranceisboring.com. Username: benefits@femcentre.com Password: FEM

Print Name: _____ Signature _____ Date _____

DIGITAL COPY:

**BCBS of Texas Provider Finder**:
www.bcbstx.com
Click on "Find a Doctor or Hospital" Fill in your state and Click on "Search as Guest"
Click on "Search In-Network Providers"
Select one of the following under the Plans dropdown
~For the PPO plan, select "Blue Choice PPO [BCA]
~For the HMO plan, select "Blue Advantage HMO [BAV]
Select your "Browse By" option or search provider's name.
For the HMO plans, select a provider from the list. Provide their PCP# (alpha-numeric) with your plan election

**Sun Life Dental Provider Finder**
www.sunlifedentalbenefits.com/find-a-dentist/

**Sun Life Vision Provider Finder**
www.vsp.com/eye-doctor