ENROLLMENT FORM

The Following Plan Options Are Effective

June 1, 2020 – May 31, 2021

STEP 1 — COMPLETE THIS SECTION WITH YOUR PERSONAL INFORMATION

You must provide information in every section in order for us to process your enrollment form.

Last Name	First Name	Middle Initial	Social Security Number
			- -

Street Address

City	County	State	ZIP Code

Phone	Gender	Birth Date (MM/DD/YYYY)	Age	Marital Status
( )	❑ Male ❑ Female	/ /		

OFFICE USE ONLY

❑ New Hire ❑ Life Event ❑ Open Enrollment **Hire Date:** **Coverage. Eff Date:** **Class:**

STEP 2 — SPOUSE AND DEPENDENT INFORMATION

Enter the information below for eligible family members.

If you have more than three (3) dependents complete an additional form and include it with this form.

	Dependent First Name	Dependent Last Name	Middle Initial		
1	Social Security Number - -	Gender ❑ Male ❑ Female	Age	Birth Date (MM/DD/YYYY) / /	❑ Medical ❑ Dental ❑ Vision
2	Dependent First Name	Dependent Last Name	Middle Initial		
	Social Security Number - -	Gender ❑ Male ❑ Female	Age	Birth Date (MM/DD/YYYY) / /	❑ Medical ❑ Dental ❑ Vision
3	Dependent First Name	Dependent Last Name	Middle Initial		
	Social Security Number - -	Gender ❑ Male ❑ Female	Age	Birth Date (MM/DD/YYYY) / /	❑ Medical ❑ Dental ❑ Vision

IMPORTANT: If any dependent listed above is covered under the Health, Dental or Vision Plan and does ***NOT*** reside at the address shown in Step 1 of this form, please provide their current address below:

Street Address			
City	County	State	ZIP Code

STEP 3 — CHOOSE YOUR BENEFITS: Pre-Tax

*Deductions out of your paycheck for the benefits below will be on a **Pre-Tax** basis.*

1 — Medical/Rx

❑ I wish to waive coverage ❑ Same as last year

PROVIDER	Total Health Care	Total Health Care	Total Health Care
Plan Name	HMO 3000 (Base)	HMO 1000 (Buy Up)	POS Mid Plan
Single	❑ $57.15	❑ $93.59	❑ $264.40
Two Person	❑ $220.43	❑ $293.31	❑ $617.57
Family	❑ $400.04	❑ $513.01	❑ $957.23

PCP 1 #:_____

PCP 2 (if applicable) #:_____

Total Bi-Weekly Medical/Rx Cost $

2 — Dental

❑ I wish to waive coverage ❑ Same as last year

PROVIDER	Guardian	
Plan Name	DHMO	PPO
Single	❑ $8.30	❑ $25.80
EE + Spouse	❑ $16.36	❑ $48.44
EE + Child(ren)	❑ $17.52	❑ $65.12
Family	❑ $25.57	❑ $87.75

Total Bi-Weekly Dental Cost $

Vision

❑ I wish to waive coverage ❑ Same as last year

PROVIDER	NVA
Plan Name	PPO
Single	❑ $3.06
Two Person	❑ $5.52
Family	❑ $7.96

Total Bi-Weekly Vision Cost $

ENROLLMENT FORM *(Continued)*

Employer Paid Coverage

PROVIDER	Guardian
Life/AD&D	Flat $10,000

BENEFICIARY INFORMATION FOR LIFE INSURANCE/AD&D (*Primary beneficiary required*) **Circle One:**

Primary: Last Name	First	MI	Relationship	Social Security Number	%

NOTE: If you wish to designate more than one primary or contingent beneficiary, please attach a separate sheet of paper. A contingent beneficiary will receive benefits only if the primary beneficiary does not survive you. Beneficiary designation for Life Insurance may be changed at any time. The percentage for either the primary or the contingent beneficiary category must equal 100%.

Optional Life

❑ I wish to waive coverage
❑ Same as last year

*** EOI is required if not currently enrolled or if there is an increase in coverage amount**

PROVIDER		Guardian			
EE Election *	EE Cost	Spouse Election	Spouse Cost	Child Election	Child Cost
❑ $100,000	$_____	❑ $50,000	$_____	❑ $10,000	$_____
❑ $75,000		❑ $37,500		❑ $7,500	
❑ $50,000		❑ $25,000		❑ $5,000	
❑ $25,000		❑ $12,500		❑ $2,500	

	Bi-Weekly cost per Coverage Amount			
EMPLOYEE AGE	$25,000	$50,000	$75,000	$100,000
<29	$0.69	$1.38	$2.08	$2.77
30-34	$0.81	$1.62	$2.42	$3.23
35-39	$1.27	$2.54	$3.81	$5.08
40-44	$2.19	$4.38	$6.58	$8.77
45-49	$3.46	$6.92	$10.38	$13.85
50-54	$5.42	$10.85	$16.27	$21.69
55-59	$9.46	$18.92	$28.38	$37.85
60-64	$15.69	$31.38	$47.08	$62.77
65-69	$25.04	$50.08	$75.12	$100.15
70-74	$39.12	$78.23	$117.35	$156.46

Spouse Rate	Bi-Weekly cost per Coverage Amount			
BASED ON EE's AGE	$12,500	$25,000	$37,500	$50,000
<29	$0.35	$0.69	$1.04	$1.38
30-34	$0.40	$0.81	$1.21	$1.62
35-39	$0.63	$1.27	$1.90	$2.54
40-44	$1.10	$2.19	$3.29	$4.38
45-49	$1.73	$3.46	$5.19	$6.92
50-54	$2.71	$5.42	$8.13	$10.85
55-59	$4.73	$9.46	$14.19	$18.92
60-64	$7.85	$15.69	$23.54	$31.38
65-69	$12.52	$25.04	$37.56	$50.08
70-74	$19.56	$39.12	$58.67	$78.23

Spouse coverage cannot exceed 50% of Employee benefit.

Child(ren)	Bi-Weekly cost per Coverage Amount			
	$2,500	$5,000	$7,500	$10,000
	$0.18	$0.37	$0.55	$0.74

Accident

❑ I wish to waive coverage
❑ Same as last year

PROVIDER	Guardian
Single	❑ $5.58
EE + Spouse	❑ $8.63
EE + Child(ren)	❑ $8.81
Family	❑ $11.85
Total Bi-Weekly Accident Cost	$

Critical Illness

❑ I wish to waive coverage
❑ Same as last year

*** EOI is required if not currently enrolled**

EMPLOYEE AGE	Employee		Spouse *(Rate is based upon Employees Age)*	
	$5,000	$10,000	$2,500	$5,000
<30	$3.72	$6.12	$2.01	$3.21
30-39	$4.96	$8.47	$2.70	$4.45
40-49	$8.49	$15.16	$4.64	$7.97
50-59	$14.46	$26.40	$7.99	$13.95
60-69	$21.51	$39.65	$11.92	$20.99
70+	$40.61	$76.54	$22.13	$40.10
Total Bi-Weekly Critical Illness			$	

Voluntary Short Term Disability

❑ Enroll* ❑ Waive
❑ Same as last year

*** EOI is required if not currently enrolled**

PROVIDER	Guardian

Benefit: 60 % of weekly income to a max of $750 per week

To determine your bi-weekly cost:

Insert Weekly Income $_____ multiply times 60% (not to exceed $750) = $_____ X $.170 =Your Monthly Cost
$_____ X 12 months = $_____ divided by 26 pay periods = $_____ Bi-weekly Cost

(Example: $500 per week multiplied by .6 = $300 weekly benefit x $.17 = $51.00 per monthly multiplied by12 months =$612 annual cost divided by 26 pay periods = $23.54 Bi-weekly Cost)

YOUR TOTAL BI-WEEKLY COST
(add Optional Life and STD)
$

Signature/Authorization

While every effort has been made to assure accuracy in the plan definitions on this form, I understand that this is strictly an election form. The contracts that my employer has signed with the insurance carriers and plan documents will be binding. I understand that this election may not be changed during the plan year unless I have a qualified status change and that unused allocations, if any, by law, will be forfeited according to the plan documents. I authorize my employer to reduce my wages by the amounts required (if needed) to pay for the Flexible Benefit Options I have elected. My signature below acknowledges my elections on pages 1, & 2.

X _____

Signature **Date**