Harold Beck & Sons, Inc. | 2017-2018 Benefits Election Form

For coverage effective October 1, 2017 – September 30, 2018

This Health Insurance Election Form provides you with your benefit options. Please complete this form in its entirety and return it to Human Resources prior to your coverage effective date.

Employee Information

LAST NAME:	FIRST NAME:	MI:

HOME ADDRESS:	CITY:	STATE:	ZIP:

HOME PHONE:	MOBILE:	EMAIL:	DATE OF HIRE:	COVERAGE EFFECTIVE DATE:

Reason for Enrollment/Change

- ☐ New Enrollment
- ☐ Address Change Only
- ☐ Birth or Adoption of Child
- ☐ Spouse Lost/Gained Coverage
- ☐ Open Enrollment
- ☐ Marriage
- ☐ Divorce/Legal Separation
- ☐ Other: _____

Covered Employee & Dependent Information

Complete the following section for yourself and all covered dependents.

Full Name	M/F	Relationship	Birth Date	SSN	Coverage Elections
		SELF			☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental

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Coverage Options

If you are <u>making changes</u> to your benefit elections or enrolling for the first time, please check the applicable coverages below:

☐ Medical ☐ Dental ☐ Health Care FSA ☐ Dependent Care FSA

Please check the box for the plan & coverage option you would like for the 2017-2018 plan year.

Medical Coverage	Employee Only	Employee+Child(ren)	Employee+Spouse	Family	Waive Coverage*
Meritain/Aetna Open Choice PPO Plan	☐	☐	☐	☐	☐

*** If you are waiving coverage, attach a copy of your other group health coverage identification card and provide the following information:**

Insurance Company: _____ **Policy #:** _____ **Primary Insured:** _____

Dental Coverage	Employee Only	Employee+Child(ren)	Employee+Spouse	Family	Waive Coverage
Guardian Dental PPO Plan	☐	☐	☐	☐	☐

Flexible Spending Account (FSA)

☐ **<u>Health Care Flexible Spending Account</u>:** You may contribute a maximum of $2,600 per year

Annual Contribution: $ _____ **Per Pay Contribution: $** _____

☐ **<u>Dependent Care Flexible Spending Account</u>:** You may contribute up to $2,500 (if single) or $5,000 (if married) per year

Annual Contribution: $ _____ **Per Pay Contribution: $** _____

Payroll Deduction Authorization

I agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected under the group benefit plan and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option selected is set forth on the schedule above.

I understand that:

1. I cannot change or revoke this benefit election or compensation reduction for medical or dental, as of any date prior to next October 1, 2018, unless I qualify for a statutorily permissible change through a change in family status (i.e. (a) marriage, divorce, death of a spouse or child, birth or adoption of a child, (b) termination or commencement of employment of a spouse, (c) change from benefits-eligible to benefits-ineligible employee status or the reverse, of myself or my spouse, (d) taking unpaid leave of absence by myself or my spouse which may create COBRA eligibility, (e) a significant cost or coverage change hereunder and such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service).
2. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease.
3. Prior to October 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not enroll, I will receive the medical and/or dental plan equivalent to my current coverage at the new contribution rates.
4. The Plan Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the group benefit plan if such action is believed advisable or necessary in order to satisfy certain provisions of the Internal Revenue Code.
5. The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.

☐ **I acknowledge that I have received the Summary of Benefits and Coverage as required by the Patient Protection Affordable Care Act.**

Employee Name: _____ **Date of Birth:** _____

Employee Signature: _____ **Date:** _____