Employee Name

Check the box of the plan you would like to select:

MEDICAL OPTIONS EFFECTIVE 5/1/2024

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
OPTION 1 HMO : $3,000 Ded	☐ $60.00	☐ $140.00	☐ $140.00	☐ $200.00
OPTION 2 HMO : $5,000 Ded	☐ $25.00	☐ $65.00	☐ $65.00	☐ $100.00
OPTION 3 POS : $2,500 Ded	☐ $90.00	☐ $205.00	☐ $205.00	☐ $305.00
OPTION 4 HMO HSA : $5,000 Ded	☐ $17.50	☐ $50.00	☐ $50.00	☐ $75.00
If selecting HMO HSA $5,000, please indicate amount here if you would like an additional amount deducted per pay period from your check to fund your HSA account: $_____				

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or your spouse's death; a change in the number of your dependents due to birth, adoption, placement for adoption, or death; a change in employment status for you, your spouse or dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes your dependent to satisfy or cease to satisfy status as a dependent; a change in your, your spouse's or your dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events are defined in the Summary Plan Description and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a benefit I have selected for the plan year changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

Signature **Date**

Name

Address

City **State** **Zip**

—OR—

Waiver of election. I have reviewed the Group Medical Plan offers and at this time I am waiving my right to election. If you refuse coverage for yourself then you automatically refuse coverage for your dependents. If you refuse coverage now, and later request to add that benefit, your coverage may be limited.

WAIVE MEDICAL ☐

Signature Date