Application for Before-Tax Benefits Enrollment or Change -- Salaried

1. CHECK OFF THE ACTION THAT YOU ARE PRESENTLY REQUESTING

Effective Date of the Action:
_____/_____/_____

☐ New Enrollment ☐ Info Change ☐ Add Dependent
☐ Name/Address Change ☐ Cancel Coverage ☐ Cancel Dependent

If requesting a change, is it a result of a life event? Check any that apply. Include documentation.
Date of Event:
_____/_____/_____

☐ Marriage ☐ Loss of spouse's health coverage
☐ Divorce/Legal Separation ☐ Birth/Adoption of child

Annual Base Salary as of 9/1/99 or as of hire date if later:

2. EMPLOYEE INFORMATION (Please Print)

Employment Status: ☐ Full Time ☐ Disabled ☐ Retired ☐ COBRA

Employee's Last Name, First Name, MI	Social Security Number	Date of Birth

Address	City, State, Zip

Date of Hire	Job Title	Date Transferred from HMO

Sex	Marital Status	Group/Co./Division Name:	Group Number (HR will complete)
	Single _____ Married _____ Divorced _____	(HR will complete)	

If Enrolled Under COBRA: Date of Qualifying Event ____/____/____ Qualifying Event:

3. ELIGIBLE DEPENDENTS -- LIST SPOUSE FIRST. (If you need more space, attach a sheet of paper)

First Name, MI	Last Name (if differs)	Sex	Relationship to Employee	Birthdate	SSN	Full time student 19 or older?*
			Spouse			

* Complete the following for each child, 19 or older, who attends an accredited school full-time. Use second sheet if needed.

School Name: Term Begins: _____/_____/_____ Expected Graduation Date: _____/_____/_____

4. OTHER COVERAGE INFORMATION

Are you or any eligible family members currently covered by other group health coverage? _____ Yes _____No

If you answered Yes above, check off the appropriate boxes below to show who is covered by the other coverage and complete the rest of Section 4.

☐ Myself ☐ My Spouse ☐ My dependent children

Name and Address of Other Coverage Carrier	To Whom is the other coverage issued?
	☐ Myself ☐ My Spouse ☐ Other

BEFORE TAX BENEFIT CHOICES

(You will automatically be enrolled for Short Term Disability and Business Travel Accident)

Make your choices for your before-tax benefits below. The cost of these benefit is paid with your company-provided FLEX DOLLARS. If the benefits you choose cost more, you'll pay for them with before-tax dollars from your pay each pay period.

MEDCIAL PLAN: You have $75 Flex dollars if single; $192.50 Flex dollars to spend on your choices below if covering yourself & family

Check the box next to the option and type of coverage you want -- for yourself only or yourself and family. The cost of each option is listed by the box. If you DO NOT want medical and/or dental coverage, check the box next to "Decline Coverage." -- Use the Flex Dollar Worksheet to help you determine your use of flex dollars.

		YOURSELF		YOURSELF & FAMILY	*Costs are per Pay Period (a)*
Network Choice (PPO), if available in your area	☐	$87.50	☐	$212.50	
HMO (Write in costs for Local Area HMO, if available)	☐	$ _____	☐	$ _____	
Traditional (Not available if you live in PPO area)	☐	$109	☐	$252.50	
Budget Saver	☐	$50	☐	$155	**Write in Cost:** $ _____
Decline Medical Coverage (Get Money Back)	☐	($75)	☐	($75)	

DENTAL PLAN: You have $8.50 Flex dollars if single; $22.00 Flex dollars to spend on your choices below if covering yourself & family

		YOURSELF		YOURSELF & FAMILY	*Costs are per Pay Period (b)*
Basic Plus	☐	$13.73	☐	$36.45	
Basic	☐	$9.87	☐	$25.03	**Write in Cost:** $ _____
Decline Dental Coverage (Get Money Back)	☐	($4.50)	☐	($4.50)	

VISION PLAN: You have a total of $23.15 to spend on vision/ basic life & AD & D/LTD -- below

			Cost is per Pay Period (C)
Single	☐	$3.45	
Family	☐	$7.96	
Decline	☐		$ _____

BASIC LIFE/AD & D INSURANCE FOR YOURSELF (Also complete the Life Insurance Beneficiary Designation Form)

		Cost Calculation for Life Insurance	*Cost is per Pay Period (d)*
2X Benefit Base Pay Rounded to Highest Thousand	☐		
1X Benefit Base Pay Rounded to Highest Thousand	☐	**Coverage Amount:** $ _____	**(Annual Salary X 1/2, 1 or 2**
1/2X Benefit Base Pay Rounded to Highest Thousand	☐	**Divided by $1,000 =** $ _____	**rounded to the highest thousand)**
.	☐	**Times .26** _____	**or enter $50,000)**
		= Monthly Rate X 12 divided by 24	$ _____

LONG TERM DISABILITY FOR YOURSELF

		Cost Calculation for Long Term Disability	*Cost is per Pay Period (e)*
66-2/3% of your wages (see SPD for definition)	☐ .45 per $100		
60% of your wages (see SPD for definition)	☐ .35 per $100	**Annualized Salary** $ _____	
50% of your wages (see SPD for definition)	☐ .22 per $100	**Divided by $100 =:** $ _____	
		Times _____ = $ _____	
		Divided by 24 equals	$ _____

REIMBURSEMENT ACCOUNTS: PLEASE COMPLETE SEPARATE ENROLLMENT FORM FOR REIMBURSEMENT ACCOUNTS

FLEX TIME

		Cost Calculation for Flex Day	*Cost is per Pay Period (f)*
One Extra Flex Day	☐		
Decline Flex Day	☐	**Annual Salary/260** $ _____	
		divided by 24 = $ _____	$ _____

TOTAL COST: (a _____ + b _____ + c _____ + d _____ + e _____ + f _____) minus total flex dollars from worksheet $_____ = Cost per Pay $ _____

ACKNOWLEDGEMENT & SIGNATURE

I have read and understand the benefit choices available to me. I confirm the choices I have made for myself and my eligible dependents and authorize the company to reduce my pay by the cost of any before tax benefits which are more than my company-provided flex dollars. I also confirm that the dependent information is correct to the best of my knowledge. I understand that the choices I have made on this form cannot be changed until the next open enrollment period unless I have a change in my family status as defined by law. I also understand that I will lose any money left in my reimbursement accounts after the end of a claim period.

_____ _____

Signature Date

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Location:

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Address	City, State, Zip

Date of Hire	Job Title	Date Transferred from HMO

Sex	Marital Status	Group/Co./Division Name	Group Number (HR will complete)
	Single _____ Married _____ Divorced _____	HR will complete	

AFTER-TAX BENEFIT CHOICES

Make your choices for your after-tax benefits below. The cost of these benefits are paid by you on an after-tax basis.

SUPPLEMENTAL LIFE FOR YOURSELF (Your beneficiary for Basic Life & AD & D will be the same for Supplemental Life

Life Insurance Amounts over $250,000 will be subject to Evidence of Insurability. Only Amounts up to $250,000 will be put into effect until the carrier approves the remaining amount. Please obtain evidence of insurability forms from your HR Representative

		Supplemental Age Rates per $1,000 per Month			
1X Benefit Base Pay	☐	Under 30	0.063	55 - 59	.612
2X Benefit Base Pay	☐	30-34	0.072	60 - 64	.963
3X Benefit Base Pay	☐	35-39	0.09	65 +	3.087
4X Benefit Base Pay	☐	40-44	0.144		
5X Benefit Base Pay	☐	45-49	0.234		
Decline	☐	50 - 54	0.387		

Cost Calculation for Life Insurance

Your Age (on 1/1/00) _____
Coverage Amount: $ _____
Divided by $1,000 = $ _____
X Age Rate _____
= Monthly Rate (See Age/Rate Chart) x 12 / 24 $ _____

Cost is per Pay Period (a)

(Salary x election rounded to the highest thousand)

SUPPLEMENTAL AD & D FOR YOURSELF AND/OR YOUR FAMILY

		Yourself Only		**Your Family**
$50,000	☐	**$0.65**	☐	**$1.05**
$75,000	☐	**$0.98**	☐	**$1.58**
$100,000	☐	**$1.30**	☐	**$2.10**
$125,000	☐	**$1.63**	☐	**$2.63**
$150,000	☐	**$1.80**	☐	**$3.15**
$175,000	☐	**$2.28**	☐	**$3.68**
$200,000	☐	**$2.60**	☐	**$4.20**
$225,000	☐	**$2.93**	☐	**$4.73**
$250,000	☐	**$3.25**	☐	**$5.25**
$300,000	☐	**$3.90**	☐	**$6.30**
$350,000	☐	**$4.20**	☐	**$7.35**
$400,000	☐	**$5.20**	☐	**$8.40**
$450,000	☐	**$5.85**	☐	**$9.45**
$500,000	☐	**$6.50**	☐	**$10.50**
$550,000	☐	**$7.15**	☐	**$11.55**
$600,000	☐	**$7.80**	☐	**$12.60**
$650,000	☐	**$8.45**	☐	**$13.65**
$700,000	☐	**$9.10**	☐	**$14.70**
$750,000	☐	**$9.75**	☐	**$15.75**
$800,000	☐	**$10.40**	☐	**$16.80**
$850,000	☐	**$11.05**	☐	**$17.85**
$900,000	☐	**$11.70**	☐	**$18.90**
$950,000	☐	**$12.35**	☐	**$19.95**
$1,000,000	☐	**$13.00**	☐	**$21.00**
Decline	☐		☐	

Cost is per Pay Period (b)

$ _____

LIFE INSURANCE COVERAGE FOR YOUR SPOUSE

$10,000 ☐
$20,000 ☐
$30,000 ☐
$40,000 ☐
$50,000 ☐
Decline ☐

Cost Calculation for Spouse's Life Insurance

Spouse's Age on 1/1/00 _____
Coverage Amount: $ _____
Divided by $1,000 = $ _____
X Spouse's Age Rate _____
= Monthly Rate (See Age/Rate Chart) x 12//24 $ _____

Cost is per Pay Period (c)

Spouse's DOB _____/_____/_____

(see supplemental life chart above)

LIFE INSURANCE COVERAGE FOR YOUR CHILD(REN)

$2,000	☐	$0.10
$5,000	☐	$0.25
$10,000	☐	$0.50
Decline	☐	

Cost is per Pay Period (d)

$ _____

TOTAL COST PER PAY PERIOD **(a)** _____ **+ (b)** _____ **+ (C)** _____ **+ (d)** _____ **=** **$** _____

ACKNOWLEDGEMENT & SIGNATURE

I have read and understand the benefit choices available to me. I confirm the choices I have made for myself and my eligible dependents and authorize the company to reduce my pay by the cost of any after tax benefits.

_____ _____
Signature Date