

## 2014-2015 BENEFITS ELECTION FORM

Date of Hire: \_\_\_\_\_

☐ New Hire ☐ Status Change

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**You must make an election for each benefit (even if declining coverage). All rates are effective July 1, 2014.**

### 1. MEDICAL: UnitedHealthcare (Choose one option below):

| <u>Medical: Basic Option</u>                   | <u>Bi-Weekly</u> | <u>Medical: High Option</u>                    | <u>Bi-Weekly</u> |
|------------------------------------------------|------------------|------------------------------------------------|------------------|
| <input type="checkbox"/> Employee Only         | \$26.83          | <input type="checkbox"/> Employee Only         | \$ 46.68         |
| <input type="checkbox"/> Employee + Spouse     | \$104.90         | <input type="checkbox"/> Employee + Spouse     | \$ 167.07        |
| <input type="checkbox"/> Employee + Child(ren) | \$80.50          | <input type="checkbox"/> Employee + Child(ren) | \$ 135.13        |
| <input type="checkbox"/> Employee + Family     | \$168.33         | <input type="checkbox"/> Employee + Family     | \$ 243.24        |

**DECLINE MEDICAL COVERAGE:** ☐

(If selected, please complete Employee Declination Acknowledgement on page 3)

### 2. DENTAL: UnitedHealthcare (Choose one option below):

| <u>Plan</u>                                      | <u>Bi-Weekly</u> |
|--------------------------------------------------|------------------|
| <input type="checkbox"/> Employee Only           | \$ 1.81          |
| <input type="checkbox"/> Employee + Spouse       | \$ 7.06          |
| <input type="checkbox"/> Employee + Child(ren)   | \$ 5.42          |
| <input type="checkbox"/> Employee + Family       | \$ 11.34         |
| <input type="checkbox"/> Decline Dental Coverage |                  |

### 3. VISION: UnitedHealthcare (Choose one option below):

| <u>Plan</u>                                      | <u>Bi-Weekly</u> |
|--------------------------------------------------|------------------|
| <input type="checkbox"/> Employee Only           | \$ 0.23          |
| <input type="checkbox"/> Employee + Spouse       | \$ 0.89          |
| <input type="checkbox"/> Employee + Child(ren)   | \$ 0.68          |
| <input type="checkbox"/> Employee + Family       | \$ 1.42          |
| <input type="checkbox"/> Decline Vision Coverage |                  |

### Required Dependent Information

Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER: \_\_\_\_\_

Social Security Numbers are legally required for covered dependents by the insurance carrier. If covering additional dependents, please provide on separate page.

**4. BASIC LIFE & AD&D:** Basic Life is 2x your base annual salary up to \$500,000. This coverage is provided to you at **no cost**. You must designate a beneficiary.

Primary Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ (\_\_\_\_%)

Primary Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ (\_\_\_\_%)

**Must Equal 100 %**

(Optional)

Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ (\_\_\_\_%)

Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ (\_\_\_\_%)

**Must Equal 100 %**

**Social Security Numbers are required for purposes of locating beneficiaries. If additional beneficiary designations are needed, please provide on separate page.**

**For the following supplemental benefits, please refer to attached Cost Summary for rates and calculation examples.**

**5. EMPLOYEE SUPPLEMENTAL LIFE:** You may purchase up to 1x your base annual salary up to \$500,000. A **Statement of Health** will be required for amounts over \$200,000. Beneficiary for Supplemental Life will be the same as Basic Life unless noted otherwise.

☐ Enroll ☐ Decline Coverage

**6. EMPLOYEE SUPPLEMENTAL AD&D:** You may purchase up to 1x your base annual salary up to \$500,000.

☐ Enroll ☐ Decline Coverage

**7. SUPPLEMENTAL SPOUSE LIFE:** There must be an election for the Employee Supplemental Life in order to purchase coverage for a spouse. Choose additional life insurance for your spouse in units of \$5,000 up to a maximum of \$150,000 (cannot exceed 50% of the employee's base annual salary). A **Statement of Health** will be required for amounts over \$50,000.

☐ Enroll ☐ Decline Coverage

Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Benefit Amount: \$ \_\_\_\_\_

**8. SUPPLEMENTAL DEPENDENT CHILD LIFE:** There must be an election for the Employee Supplemental Life in order to purchase coverage for a dependent child. Choose additional life insurance for your dependent children in units of \$2,500 up to a maximum of \$10,000. Amount must be equal per child.

☐ Enroll ☐ Decline Coverage

Benefit Amount: \$ \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

**9. SHORT TERM DISABILITY:** ☐ Enroll ☐ Decline Coverage

Refer to Cost Summary for cost calculation.

**10. FLEXIBLE SPENDING ACCOUNT (FSA):** Elect to participate in the Flexible Spending Account plan for the current calendar year. You can contribute to your Health Care Account and to your Dependent Care Account each calendar year.

☐ Enroll      ☐ Decline Coverage

Health Care Contribution (**Annual Amount**): \$ \_\_\_\_\_

Dependent Care Contribution (**Annual Amount**): \$ \_\_\_\_\_

*By default, United Healthcare will make Automatic Reimbursement payments from your Health Care FSA for expenses submitted to, but not payable by, your medical plan. Expenses will be automatically reimbursed through your FSA and will be incurred by you (and/or your spouse and/or your eligible dependents) and will not be reimbursed by another plan. You cannot use the expenses reimbursed through the FSA program as deductions or credits when filing your individual income tax return. To opt out of Automatic Reimbursement visit [www.myuhc.com](http://www.myuhc.com).*

### Certification & Signature

**I certify that I have read the benefits PowerPoint summary and understand the benefits for which I am enrolling.** I hereby authorize my employer to make applicable changes, as noted above, to my current benefit elections and to deduct from my salary, under the Section 125 premium conversion, in the amount necessary to pay for the coverage(s) elected on this form. Such elections will remain in effect and cannot be changed during the plan year, unless the change is due to and consistent with a change in family status.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### EMPLOYEE DECLINATION ACKNOWLEDGEMENT

If you wish to decline coverage for yourself and/or your dependents, you must sign below and provide a reason for declining coverage for yourself and any dependents.

Coverage under another employer's medical plan: Employer Name: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Plan # \_\_\_\_\_

Other reason(s): \_\_\_\_\_

I acknowledge that I have been given the opportunity to enroll myself and/or eligible dependents in my employer's medical (including dental and vision) plan(s). I am declining to enroll myself and/or eligible dependents in all or some of the stated plans.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Premium Calculation Worksheet**  
*(This worksheet is for your information only)*  
**Your Cost at a Glance: Current Rates (subject to change)**

|                                       |                                           |
|---------------------------------------|-------------------------------------------|
| <b>Basic Life and Basic AD&amp;D</b>  | Provided at no cost to you.               |
| <b>Employee Supplemental Life</b>     | \$.27 per \$1,000 of coverage             |
| <b>Supplemental Spouse Life</b>       | \$.27 per \$1,000 of coverage             |
| <b>Supplemental Child(ren) Life</b>   | \$.20 per \$1,000 of coverage             |
| <b>Employee Supplemental AD&amp;D</b> | \$0.03 per \$1,000 of coverage            |
| <b>Short-Term Disability (STD)</b>    | \$0.29 per \$10 of weekly covered benefit |
| <b>Long-Term Disability (LTD)</b>     | Provided at no cost to you.               |

**Premium Calculation Examples:**

**Employee Supplemental Life**

Example: Employee earning \$55,200 per year elects Supplemental Life of 1 times earnings. Earnings are rounded to the next higher \$1,000 multiple (\$56,000 in this example).  
 $\$56,000 \times \$0.27 = \$15,120 \div \$1,000 = \$15.12$  per month  
 $(\$15.12 \times 12 \text{ months}) = \$181.44/\text{yr.}$   
 $\$181.44/\text{yr.} \div 26 \text{ weeks} = \$6.98$  bi-weekly

**Employee Supplemental AD&D**

Example: Employee elects Supplemental AD&D. Coverage matches the Supplemental Life coverage of \$56,000.  
 $\$56,000 \times \$0.03 = \$1,680 \div \$1,000 = \$1.68$  per month  
 $(\$1.68 \times 12 \text{ months}) = \$20.16/\text{yr.}$   
 $\$20.16/\text{yr.} \div 26 \text{ weeks} = \$0.78$  bi-weekly

**Supplemental Child(ren) Life**

There must be an election for the Employee Supplemental Life in order to purchase coverage for a dependent child.  
 Example: Employee enrolls his 3 children in the Dependent Life plan at the \$10,000 coverage level (for each child). Premium is based on coverage level, not the aggregate of the children's coverage.  
 $\$10,000 \times \$0.20 = \$2,000 \div \$1,000 = \$2.00$  per month  
 $(\$2.00 \times 12 \text{ months}) = \$24/\text{yr.}$   
 $\$24/\text{yr.} \div 26 \text{ weeks} = \$0.92$  bi-weekly covers all 3 children at \$10,000 of coverage for each child

**Supplemental Spouse Life**

There must be an election for the Employee Supplemental Life in order to purchase coverage for a spouse.  
 Example: Employee enrolls spouse in the Supplemental Spouse Life plan at the \$20,000 coverage level.  
 $\$20,000 \times \$0.27 = \$5,400 \div \$1,000 = \$5.40$  per month  
 $(\$5.40 \times 12 \text{ months}) = \$64.80/\text{yr.}$   
 $\$64.80/\text{yr.} \div 26 \text{ weeks} = \$2.49$  bi-weekly

**Short-Term Disability (STD)**

Example: Employee earning \$1,000 per week elects STD coverage. The maximum weekly benefit is 60% of weekly earnings up to \$2,500 per week.  
 In this example, it is \$600 per week in STD benefits. (60% of \$1,000)  
 $\$600 \times \$0.29 = \$174 \div \$10 = \$17.40$  per month  
 $(\$17.40 \times 12 \text{ months}) = \$208.80/\text{yr.}$   
 $\$208.80/\text{yr.} \div 26 \text{ weeks} = \$8.03$  bi-weekly

**Premium Calculation Worksheet:**

**Employee Supplemental Life (Insert Annual Earnings to Calculate)**

$\$ \rule{1cm}{0.4pt} \times \$0.27 = \rule{1cm}{0.4pt} \div \$1,000 = \$ \rule{1cm}{0.4pt}$  per month  
 $(\$ \rule{1cm}{0.4pt} \times 12 \text{ months}) = \$ \rule{1cm}{0.4pt} / \text{yr.}$   
 $\$ \rule{1cm}{0.4pt} / \text{yr.} \div 26 \text{ weeks} = \$ \rule{1cm}{0.4pt}$  bi-weekly

**Employee Supplemental AD&D (Insert Annual Earnings to Calculate)**

$\$ \rule{1cm}{0.4pt} \times \$0.03 = \$ \rule{1cm}{0.4pt} \div \$1,000 = \$ \rule{1cm}{0.4pt}$  per month  
 $(\$ \rule{1cm}{0.4pt} \times 12 \text{ months}) = \$ \rule{1cm}{0.4pt} / \text{yr.}$   
 $\$ \rule{1cm}{0.4pt} / \text{yr.} \div 26 \text{ weeks} = \$ \rule{1cm}{0.4pt}$  bi-weekly

**Supplemental Child(ren) Life (Insert coverage level to calculate)**

$\$ \rule{1cm}{0.4pt} \times \$0.20 = \$ \rule{1cm}{0.4pt} \div \$1,000 = \$ \rule{1cm}{0.4pt}$  per month  
 $(\$ \rule{1cm}{0.4pt} \times 12 \text{ months}) = \$ \rule{1cm}{0.4pt} / \text{yr.}$   
 $\$ \rule{1cm}{0.4pt} / \text{yr.} \div 26 \text{ weeks} = \$ \rule{1cm}{0.4pt}$  bi-weekly

**Supplemental Spouse Life (Insert coverage level to calculate)**

$\$ \rule{1cm}{0.4pt} \times \$0.27 = \$ \rule{1cm}{0.4pt} \div \$1,000 = \$ \rule{1cm}{0.4pt}$  per month  
 $(\$ \rule{1cm}{0.4pt} \times 12 \text{ months}) = \$ \rule{1cm}{0.4pt} / \text{yr.}$   
 $\$ \rule{1cm}{0.4pt} / \text{yr.} \div 26 \text{ weeks} = \$ \rule{1cm}{0.4pt}$  bi-weekly

**Short-Term Disability (STD)**

*Weekly Earnings = Annual Earnings divided by 52*

*(Insert 60% of weekly earnings to calculate)*

$\$ \rule{1cm}{0.4pt} \times \$0.29 = \$ \rule{1cm}{0.4pt} \div \$10 = \$ \rule{1cm}{0.4pt}$  per month  
 $(\$ \rule{1cm}{0.4pt} \times 12 \text{ months}) = \$ \rule{1cm}{0.4pt} / \text{yr.}$   
 $\$ \rule{1cm}{0.4pt} / \text{yr.} \div 26 \text{ weeks} = \$ \rule{1cm}{0.4pt}$  bi-weekly