Benefit Election Form – FULL TIME

Plan year 12/1/17 to 11/30/18

Based on 12 Payrolls

Name | Location | Employee ID

Address | City | State | Zip Code

Hire Date | Date of Birth | Hours per Week | Social Security Number | Gender

Are you a tobacco user? ☐ YES ☐ NO

MEDICAL COVERAGE – Aetna

If you would like to CONTINUE COVERAGE or ENROLL for 2017-2018, please select an AETNA plan below and complete all applicable information.

1. Please select below:

Aetna Medical Plans	Employee Only	Employee + Spouse	Employee + Children	Family	Premium Amount
Option 1 - $2000	◯ $64.69	◯ $283.97	◯ $162.06	◯ 631.52	
Option 2 - $3500	◯ $0	◯ $272.58	◯ $156.54	◯ $544.30	
Option 3 - $5000	◯ $0 ($35.34 Credit)	◯ $89.48	◯ $0 ($16.85 Credit)	◯ $400.56	
Option 4 - $2750 HDHP	◯ $0	◯ $189.43	◯ $122.73	◯ $326.73	

2. If you are ENROLLING a Spouse and/or Dependent on your Medical, please complete below:

☐ Male ☐ Female	**Spouse Name:**	Date of Birth:	Social Security Number:

☐ Male ☐ Female	**(1) Child Name:**	Date of Birth:	Social Security Number:
☐ Male ☐ Female	**(2) Child Name:**	Date of Birth:	Social Security Number:
☐ Male ☐ Female	**(3) Child Name:**	Date of Birth:	Social Security Number:
☐ Male ☐ Female	**(4) Child Name:**	Date of Birth:	Social Security Number:

I have received and read my enrollment materials. I understand that by signing and submitting this form, I am making a binding election for my benefits and pay for the plan year indicated on the front of this form. I also understand that I may not change my elections until the next plan year enrollment period unless I have a "qualified change" in my family status, as explained in my enrollment materials.

EMPLOYEE SIGNATURE | DATE

If you are not enrolling in Medical Coverage, please complete the Waiver of Coverage on the backside of this form.

WAIVER OF MEDICAL COVERAGE

This is to certify that I have been given the opportunity to apply for Group Medical Coverage available to me through my employer and I have decided to waive coverage for the 2017-2018 plan year because:

- ◯ I am covered by another group plan (spouse's plan, parent's plan or other employer plan)
- ◯ I am covered by an individual medical plan
- ◯ I am covered by Medicare
- ◯ Other: _____

By waiving your enrollment rights at this time, you understand that you cannot enroll in the group plan(s) unless you have a qualifying event or during your employer's open enrollment period.

Signature of Waiver Date