# 2020 BENEFIT ELECTION & PAYROLL DEDUCTION AUTHORIZATION FORM

## 1. ENROLLMENT TYPE

☐ Open Enrollment ☐ New Hire/Rehire ☐ Reinstatement ☐ Loss of Coverage ☐ COBRA/Cal COBRA

☐ Court Order/Marital ☐ New Dependent ☐ Residence Change ☐ Material Change ☐ Other (complete section 13)

## 2. EMPLOYER INFORMATION

**EMPLOYER NAME** | **DATE OF HIRE** | **# AVG. HRS/ WEEK** | **JOB TITLE** | **ANNUAL SALARY**

**EMPLOYER ADDRESS** | **CITY** | **STATE** | **ZIP CODE**

## 3. PERSONAL INFORMATION

**EMPLOYEE NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

**RESIDENCE ADDRESS** | **CITY** | **STATE** | **ZIP CODE**

MAILING ADDRESS | CITY | STATE | ZIP CODE

☐ Same as Residence

**E-MAIL** | **PRIMARY PHONE** | **SECONDARY PHONE**

**MARITAL STATUS**

☐ Single ☐ Married ☐ †Domestic Partner

**# OF CHILDREN (INCLUDING STEP CHILDREN AND CUSTODIAL DEPENDENTS) - INPUT # OF CHILDREN IN EACH AGE CATEGORY**

Minor Children (0-17): Adult Children (18-25): Disabled Children (26+):

## 4. DEPENDENT INFORMATION

**SPOUSE/†DOMESTIC PARTNER NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

SPOUSE RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

☐ Same as employee

**# 1 CHILD NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

# 1 CHILD RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

☐ Same as employee

**# 2 CHILD NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

# 2 CHILD RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

☐ Same as employee

**# 3 CHILD NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

# 3 CHILD RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

☐ Same as employee

**# 4 CHILD NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

# 4 CHILD RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

☐ Same as employee

**# 5 CHILD NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY # (IF NONE, COMPLETE SECTION 13)** | **GENDER** ☐ Male ☐ Female

# 5 CHILD RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

☐ Same as employee

†Form # dp_20 Requirement- All employee elections, applications, waivers, and declinations including a domestic partner must complete Form # dp_20 to proceed with form submission.

# PLAN SELECTION

## 5. STANDARD BENEFITS

| MEDICAL | DENTAL | VISION | ADDITIONAL LIFE - GUARANTEED | GROUP LIFE / DISABILITY / EAP |
|---|---|---|---|---|
| ☐ HMO- Plan 1 | ☐ EPO- Plan 8 | ☐ PPO- Plan 10 | ☐ Employee Add. Life | ☐ Employee Group Life |
| ☐ HMO- Plan 2 | ☐ POS– Plan 9 | | ☐ Spouse/D. Part Add. Life | ☐ Employee Group LTD |
| ☐ PPO - Plan 3 | | | ☐ Child(ren) Add. Life | ☐ Employee Assistance Program |
| ☐ PPO - Plan 4 | | | | |
| ☐ PPO - Plan 5 | | | | |

| | --- MEDICAL PARTICIPANTS --- | | --- DENTAL PARTICIPANTS --- | | --- VISION PARTICIPANTS --- | | --- ADDITIONAL LIFE PARTICIPANTS --- | | --- GROUP LIFE/LTD/EAP PARTICIPANTS --- |
|---|---|---|---|---|---|---|---|---|---|
| Employee | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Automatic Enrollment |
| Spouse/†D. Partner | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | • N/A |
| # 1 Child | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | • N/A |
| # 2 Child | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | • N/A |
| # 3 Child | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | • N/A |
| # 4 Child | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | • N/A |
| # 5 Child | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | ☐ Enroll | ☐ Waive | • N/A |

## 6. ANCILLARY BENEFITS

| SUPPLEMENT LIFE- NON-GUARANTEED | SHORT-TERM DISABILITY | HOSPITAL INDEMNITY | ACCIDENT INDEMNITY | CRITICAL ILLNESS INDEMNITY | CANCER INDEMNITY |
|---|---|---|---|---|---|
| ☐ Employee Supp. Life | ☐ Employee Limited STD | ☐ Employee Hospital | ☐ Employee Accident | ☐ Employee Critical | ☐ Employee Cancer |
| ☐ Spouse/†D.P. Supp. Life | | ☐ Spouse/†D.P. Hospital | ☐ Spouse/†D.P. Accident | ☐ Spouse/†D.P. Critical | ☐ Spouse/†D.P. Cancer |
| | | ☐ Child(ren) Hospital | ☐ Child(ren) Accident | ☐ Child(ren) Critical | ☐ Child(ren) Cancer |

## 7. OTHER MEDICAL COVERAGE

| | OTHER GROUP or V.A. | COBRA/ CAL COBRA | MEDICARE PART A/B | MEDICAID/ MEDI-CAL | STATE/ FED EXCHANGE | INDIVIDUAL/ OTHER | WAIVE COVERAGE |
|---|---|---|---|---|---|---|---|
| Employee | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |
| Spouse/†D. Partner | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |
| # 1 Child | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |
| # 2 Child | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |
| # 3 Child | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |
| # 4 Child | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |
| # 5 Child | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Covered | ☐ Uninsured |

†Form # dp_20 Requirement- All employee elections, applications, waivers, and declinations including a domestic partner must complete Form # dp_20 to proceed with form submission.

# PAYROLL DEDUCTION

## 8. BI-WEEKLY (PRE-TAX) DEDUCTION

| MEDICAL – UNITED HEALTHCARE | EMPLOYEE (ASSOCIATE ONLY) | EMPLOYEE + SPOUSE/†D. PARTNER | EMPLOYEE + CHILD/CHILDREN | EMPLOYEE + COMBINED FAMILY | CHILD ONLY (COURT ORDER) |
|---|---|---|---|---|---|
| HMO- Plan 1 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| HMO- Plan 2 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| PPO - Plan 3 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| PPO - Plan 4 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| PPO - Plan 5 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| **MEDICAL – KAISER PERMANENTE** | | | | | |
| HMO- Plan 6 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| HMO- Plan 7 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| **DENTAL – PRINCIPAL** | | | | | |
| EPO - Plan 8 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| POS - Plan 9 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |
| **VISION – VSP** | | | | | |
| PPO - Plan 10 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ☐ $0.00 | ● N/A |

| TAX-ADVANTAGE ACCOUNTS | CHECK TO ENROLL | ANNUAL CONTRIBUTION ($) | ADD SERVICE FEE ($) | DIVIDE ANNUAL PAY PERIODS (#) | EQUALS COST PER PAY PERIOD ($) |
|---|---|---|---|---|---|
| (FSA) Health Spending | ☐ | ▸ $ | + N/A | ÷ 26 | = $ |
| (FSA) Dependent Care | ☐ | ▸ $ | + N/A | ÷ 26 | = $ |
| (HSA) Health Savings | ☐ | ▸ $ | + N/A | ÷ 26 | = $ |

## 9. BI-WEEKLY (POST-TAX) DEDUCTION

| ADD. LIFE (GUARANTEED) – PRINCIPAL | CHECK TO ENROLL | RATE PER UNIT ($) | MULTIPLY NUMBER OF UNITS (#) | ADD RIDER FEE ($) | EQUALS COST PER PAY PERIOD ($) |
|---|---|---|---|---|---|
| Employee Additional Life | ☐ | ▸ $ | x # | + N/A | = $ |
| Spouse/†D. Partner Add. Life | ☐ | ▸ $ | x # | + N/A | = $ |
| Child(ren) Add. Life | ☐ | ▸ $ | x # | + N/A | = $ |
| **SUPP. LIFE (NON-GUARANTEED) - PRINCIPAL** | **CHECK TO APPLY or LEARN MORE** | **RATE PER UNIT ($)** | **MULTIPLY NUMBER OF UNITS (#)** | **ADD RIDER FEE ($)** | **EQUALS COST PER PAY PERIOD ($)** |
| Employee Supplemental Life | ☐ | ▸ $ | x # | + N/A | = $ |
| Spouse/†D. Partner Supp. Life | ☐ | ▸ $ | x N/A | + N/A | = $ |

| INDEMNITY PLANS – COLONIAL | CHECK TO APPLY or LEARN MORE | RATE PER UNIT OR TIER LEVEL ($) | MULTIPLY NUMBER OF UNITS (#) | ADD RIDER FEE ($) | EQUALS COST PER PAY PERIOD ($) |
|---|---|---|---|---|---|
| Short-Term Disability | ☐ | ▸ $ | x # | + $ | = $ |
| Hospital Indemnity | ☐ | ▸ $ | x # | + $ | = $ |
| Accident Indemnity | ☐ | ▸ $ | x N/A | + $ | = $ |
| Critical Illness Indemnity | ☐ | ▸ $ | x # | + $ | = $ |
| Cancer Indemnity | ☐ | ▸ $ | x N/A | + $ | = $ |

†Form # dp_20 Requirement- All employee elections, applications, waivers, and declinations including a domestic partner must complete Form # dp_20 to proceed with form submission.

## 10. PHYSICIAN AND FACILITY PREFERENCE (OPTIONAL)

| | MEDICAL | DENTAL | | PRIMARY | SPECIALIST | PHYSICIAN OR FACILITY NAME | MEDICAL OR DENTAL GROUP | LOCATION (CITY, STATE) | CURRENT PATIENT |
|---|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |
| INDUSTRY | ☐ | ☐ | PRACTICE | ☐ | ☐ | | | | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | | | | ☐ |

## 11. LIFE BENEFICIARY DESIGNATION

| | INSURED NAME | | BENEFICIARY NAME | BENEFICIARY SS # | USA CITIZEN | GROUP LIFE | ADD/SUP LIFE | PRIMARY | CONTINGENT | BENEFIT AMOUNT (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| INSURED | | BENEFICIARY | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | |

## 12. LANGUAGE ASSISTANCE

**PREFERRED LANGUAGE**

☐ English ☐ Other (Please Specify)

Interpreter services and plan documents may be available in your preferred language. Preferred language includes services such as sign language services, large print, audio, and other formats. Please specify your preferred language below and you will be contacted by a representative in your preferred language for additional information.

## 13. NOTES

## EMPLOYEE AGREEMENTS

### 14. ACCEPTANCE OF COVERAGE

I acknowledge and agree that the information provided herein is true and correct to the best of my knowledge. The information provided herein is the basis for the establishment of all benefits offered to me and/or my dependent family members. Any fraudulent, misleading, misrepresented, or false information provided by me may result in adjustments of payroll deductions, benefit modification, rescission, penalties, fines, and other actions. Participation in the employer benefit offering is subject to carrier approval; and eligibility definitions outlined in the plan documents. The elections I make will remain in force for the duration of the plan year, and are subject to change as a result of future benefit renewals or as a result of changes to the employer benefit offering. Other events such as changes in eligibility status may impact in force elections. I understand that medical benefit changes are allowed during special enrollment periods under guidance of federal, state, and regulatory agencies; or in measures of authoritative action. By signing below, I consent to a timely submission of the above referenced enrollments and applications. I authorize payroll deductions for participation in the employer benefit offering.

| EMPLOYEE NAME | EMPLOYEE SIGNATURE | DATE |
|---|---|---|
| | | |

### 15. DECLINATION OF COVERAGE

I acknowledge and agree that the information provided herein is true and correct to the best of my knowledge. The information provided herein is the basis for the establishment of all benefits offered to me and/or my dependent family members. Any fraudulent, misleading, misrepresented, or false information provided by me may result in adjustments of payroll deductions, benefit modification, rescission, penalties, fines and other actions. All Standard Benefits and Ancillary Benefits are being offered to me and/or my dependent family members; and I understand that I have a right to apply for all benefits offered based on my eligibility status. Although I have a right to apply, I understand that Ancillary Benefit participation may be subject to carrier approval through satisfaction of current carrier underwriting requirements. Waiver and unelected (inaction) may be deemed consequential. The waivers will remain effective for the duration of the benefit year for medical, dental, and vision benefits. I understand that medical benefit changes are allowed during special enrollment periods under guidance of federal, state, and regulatory agencies, or in measures of authoritative action. Other waivers and unelected benefits may remain so, indefinitely, for additional and supplemental life, short-term disability, hospital indemnity, accident indemnity, critical illness indemnity and cancer indemnity benefits. By signing below, I consent to a timely submission of the above referenced waivers. I authorize payroll deduction adjustments for participation changes and terminations in the employer benefit offering.

| EMPLOYEE NAME | EMPLOYEE SIGNATURE | DATE |
|---|---|---|
| | | |

### 16. EMPLOYEE ATTESTATION (OPTIONAL)

| EMPLOYEE NAME | EMPLOYEE SIGNATURE | DATE |
|---|---|---|
| | | |

### 17. EMPLOYER "ADMINISTRATOR" ATTESTATION (OPTIONAL)

| EMPLOYER "ADMINISTRATOR" NAME | EMPLOYER "ADMINISTRATOR" SIGNATURE | DATE |
|---|---|---|
| | | |