G&H TOWING

G & H Towing
August 1, 2021 – July 31, 2022
Benefits Enrollment Form

- ❑ Open Enrollment
- ❑ New Hire
- ❑ Qualified Change in Status
  - ❑ Marriage
  - ❑ Divorce
  - ❑ Gain or Loss Other Coverage
  - ❑ Other _____

A. EMPLOYEE INFORMATION

Location:

Last Name	First Name	Middle Initial	Date of Birth	Date of Hire	Gender

Street Address	Apt. No.	City	State	Zip Code

Social Security Number	Preferred Phone Number	Marital Status
		❑ Single (including widowed or divorced) ❑ Married (including separated)

Email Address	Job Title

B. MEDICAL, DENTAL & VISION INSURANCE – MONTHLY PAYROLL DEDUCTIONS

MEDICAL/RX CIGNA		DENTAL METLIFE		VISION METLIFE	
☐ Employee Only	$118.69	☐ Employee Only	$5.20	☐ Employee Only	$6.20
☐ Employee + Spouse	$262.20	☐ Employee + Family	$15.00	☐ Employee + Spouse	$12.43
☐ Employee + Child(ren)	$221.13	☐ DECLINE		☐ Employee + Child(ren)	$10.52
☐ Employee + Family	$328.10			☐ Employee + Family	$17.34
☐ DECLINE				☐ DECLINE	

C. FAMILY ENROLLMENT INFORMATION

Benefit(s) Elected Check all that apply	Dependent Name First, Middle Initial, Last	Gender M or F	Birthdate Mo/Day/Year	Relationship	Social Security # (Required)
❑ Medical ❑ Dental ❑ Vision					
❑ Medical ❑ Dental ❑ Vision					
❑ Medical ❑ Dental ❑ Vision					
❑ Medical ❑ Dental ❑ Vision					
❑ Medical ❑ Dental ❑ Vision					
❑ Medical ❑ Dental ❑ Vision					

D. VOLUNTARY SHORT & LONG TERM DISABILITY – LINCOLN

Refer to Employee Benefits Guide for rates and additional plan specifics.

Submit Evidence of Insurability Form to Lincoln if you previously waived STD and LTD a. Insurance & payroll deductions effective upon approval.

☐ **Elect Short Term Disability for $_____ per Month**	☐ **Elect Long Term Disability for $_____ per Month**
☐ **Decline Short Term Disability**	☐ **Decline Long Term Disability**

E. VOLUNTARY LIFE and AD&D INSURANCE – LINCOLN

Refer to Employee Benefits Guide for rates, election maximums and Guarantee Issue specifics. Submit Evidence of Insurability Form to Lincoln if you initially declined coverage or wish to increase your benefit. Insurance & payroll deductions effective upon approval.

Employee	Spouse	Child(ren)
☐ **Voluntary Amount: $_____**	☐ **Voluntary Amount: $_____**	☐ **Voluntary Amount: $_____**
☐ **Decline**	☐ **Decline**	☐ **Decline**

Employee Name: **Location:**

F. BENEFICIARY DESIGNATION

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Full Name & Address	Relationship	Date of Birth	Primary / Contingent	Basic / Voluntary	Benefit Percentage
			☐ Primary ☐ Contingent	☐ Basic ☐ Voluntary	
			☐ Primary ☐ Contingent	☐ Basic ☐ Voluntary	
			☐ Primary ☐ Contingent	☐ Basic ☐ Voluntary	

E. FLEXIBLE SPENDING ACCOUNT (FSA) – HealthEquity (formerly known as WageWorks)

☐ **Health Care FSA** $50 - $2,750 Annual Contribution
☐ **Waive Health Care FSA**

Per Year $_____

G. AUTHORIZATION OF PAYROLL DEDUCTIONS & CONDITIONS OF COVERAGE & AFFIRMATIVE CONSENT OF ELECTRONIC DISTRIBUTION OF EMPLOYEE BENEFITS MATERIALS

By making benefit elections on this form and signing below you are authorizing G & H Towing Company to deduct applicable premiums from your paycheck. Section 125 of the Internal Revenue Code allows participants to save taxes by electing to pay their share of premiums for Medical, Dental and Vision, and FSA coverages on a pre-tax basis. In order to capture the tax savings, certain restrictions have been placed on the plan such as you will not be able to make an insurance plan change until the end of the plan year or a qualifying event occurs – i.e. divorce, marriage, birth of a child, etc. This means that you are committed to paying the premium you select every pay period for the plan year.

I hereby apply for coverage based on the statements and answers to the questions herein. I hereby declare all answers to be true to the best of my knowledge. I have read and agreed with the terms as stated on this application. By acceptance of coverage and upon signing this enrollment form, I authorize each benefit provider, and others it designates, to share information about me with any medical provider, or other entity, where such information is reasonably necessary for treatment, payment or health care operations. I understand that the benefit providers may release information regarding services provided under my health benefits contract when requested by the organization sponsoring my benefits plan.

This Enrollment Form is provided to you as a convenience to eliminate paperwork from each benefit provider. However, this form will not cover every conceivable benefit election situation. Please contact Human Resources for benefit election forms for late enrollment or other situations not addressed in this form. In addition, please refer to Human Resources and information provided to you about specific questions you may have about your eligibility and benefit coverage.

I affirmatively consent to the electronic disclosure, via my email on file with my employer, of all Employee Benefits materials, including but not limited to, Certificates of Coverage, Summaries of Benefits & Coverage, Amendments, Summary of Material Modifications, and Annual Notices. I acknowledge that I have read this Disclosure and understand that I am entitled to withdraw my consent at any time and at no cost. I understand that I have the right to receive paper copies of all Employee Benefits documents upon request at no charge. My signature serves as an agreement to this consent.

☐ I do not consent to electronic distribution of Employee Benefits materials.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance may result in the denial of claims, cancellation or rescission of coverage and is guilty of a crime and may be subject to fines and confinement in prison.

_____

Employee Signature **Date**

Human Resources Use Only

CIGNA - Medical	METLIFE - Dental	METLIFE - Vision	LINCOLN – Life	LINCOLN –Disability	HealthEquity- FSA