INSERT LOGO

BENEFITS ENROLLMENT FORM

2022–2023 [[CLIENT NAME]] OPEN ENROLLMENT

1. EMPLOYEE INFORMATION

Name (please print):	Employee ID Number:	Social Security #:
Address:	Date of Birth (MM/DD/YYYY):	Date of Hire:
City:	State:	ZIP:
Phone Number:	Email Address:	

2. MEDICAL PLAN SELECTION (WEEKLY CONTRIBUTIONS)

Please check (✓) one box
Medical Coverage includes Prescription Drug Coverage

	IBC Value Plan	IBC Base Plan	IBC Premium Plan
Employee	☐ $29.82	☐ $69.00	☐ $82.37
Employee + Spouse	☐ $226.61	☐ $316.77	☐ $347.53
Employee + Child(ren)	☐ $148.26	☐ $218.12	☐ $241.96
Family	☐ $322.36	☐ $437.32	☐ $476.55

☐ **Waive Medical Coverage**

3. DENTAL PLAN SELECTION (WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	United Concordia Low Plan	United Concordia High Plan
Employee	☐ $7.75	☐ $8.17
Employee + Spouse	☐ $15.23	☐ $16.08
Employee + Child(ren)	☐ $13.92	☐ $16.78
Family	☐ $23.28	☐ $26.70

☐ **Waive Dental Coverage**

4. VISION PLAN SELECTION (WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	VSP Vision Plan
Employee	☐ $1.38
Employee + Spouse	☐ $2.21
Employee + Child(ren)	☐ $2.26
Family	☐ $3.64

☐ **Waive Vision Coverage**

5. DEPENDENT ENROLLMENT INFORMATION

Dependent First & Last Name	Gender (M/F)	Relationship (Spouse, DP, Child)	Date of Birth (MM/DD/YYYY)	Social Security # (required)	Add/Cancel Coverage	Select Plan(s) to Add/Cancel
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision

6. VOLUNTARY LIFE/AD&D INSURANCE – EMPLOYEE

Please check (✓) one box

[[CLIENT NAME]] provides $25,000 of Basic Life/AD&D coverage to all benefits-eligible employees at no cost to them. Employees have the option of purchasing additional Life and AD&D coverage through Guardian. You may purchase coverage in increments of $10,000 up to a maximum of $250,000.
The Guarantee Issue amount is $200,000.

☐ **Yes,** I wish to elect Employee Voluntary Life and AD&D Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Employee Voluntary Life and AD&D

NOTE: You **must** elect Voluntary Employee Life and AD&D to participate in the following Voluntary Spouse and Child(ren) Life and AD&D Plans. Employee is responsible for 100% of the premium.

7. VOLUNTARY LIFE/AD&D INSURANCE – SPOUSE

Please check (✓) one box

You may purchase Spousal coverage in increments of $5,000 up to a maximum of $100,000.
The Guarantee Issue amount is $25,000, not to exceed 50% of employee amount.

☐ **Yes,** I wish to elect Spousal Voluntary Life and AD&D Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Spousal Voluntary Life and AD&D

8. VOLUNTARY LIFE/AD&D INSURANCE – CHILD(REN)

Please check (✓) one box

You may purchase Child coverage in increments of $2,500 up to a maximum of $10,000.
The Guarantee issue amount is $10,000, not to exceed 10% of employee amount.

☐ **Yes,** I wish to elect Child(ren) Voluntary Life and AD&D Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Child(ren) Voluntary Life and AD&D

VOLUNTARY LIFE/AD&D

MONTHLY RATES PER $10,000 OF COVERAGE	
AGE	RATE
0–29	$1.25
30–34	$1.31
35–39	$1.62
40–44	$2.17
45–49	$3.24
50–54	$5.08
55–59	$7.81
60–64	$11.46
65–69	$21.41
70+	$40.74

CHILD VOLUNTARY LIFE/AD&D

MONTHLY RATE PER $2,500 OF COVERAGE	
Child	$0.51

9. VOLUNTARY SHORT-TERM DISABILITY (STD)

Please check (✓) one box

Employees have the option of purchasing voluntary STD coverage through Guardian. Guardian's STD benefit pays you anywhere from $300 to $1,200 per week, or up to **60% of your pre-disability earnings, whichever is less.**

☐ **Yes,** I wish to elect Voluntary STD coverage. **Amount Selected:** _____

☐ **No,** I do not wish to elect Voluntary STD

VOLUNTARY SHORT-TERM DISABILITY

RATES PER $10 OF WEEKLY INDEMNITY BENEFIT	
AGE	MONTHLY PREMIUM
0–24	$0.37
25-29	$0.50
30–34	$0.67
35–39	$0.55
40–44	$0.35
45–49	$0.37
50–54	$0.45
55–59	$0.55
60+	$0.80

8. HOSPITAL INDEMNITY INSURANCE (WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	Guardian Low Plan	Guardian High Plan
Employee	☐ $1.91	☐ $3.75
Employee + Spouse	☐ $3.87	☐ $7.59
Employee + Child(ren)	☐ $3.19	☐ $6.24
Family	☐ $5.14	☐ $10.08

☐ **Waive Hospital Indemnity Coverage**

9. ACCIDENT INSURANCE (WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	Guardian Low Plan	Guardian High Plan
Employee	☐ $1.65	☐ $3.04
Employee + Spouse	☐ $2.79	☐ $5.04
Employee + Child(ren)	☐ $3.01	☐ $5.18
Family	☐ $4.15	☐ $7.18

☐ **Waive Accident Coverage**

10. CRITICAL ILLNESS INSURANCE – EMPLOYEE

Please check (✓) one box

Employees have the option of purchasing Critical Illness coverage through Guardian. You may purchase coverage in increments of $10,000 up to a maximum of $20,000.

☐ **Yes,** I wish to elect Employee Critical Illness Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Employee Critical Illness Coverage.

NOTE: Includes 50% of employee benefit for children

CRITICAL ILLNESS - EMPLOYEE

MONTHLY RATES PER $10,000 OF COVERAGE	
AGE	EMPLOYEE
0–29	$4.70
30–39	$7.70
40–49	$14.50
50–59	$27.10
60–69	$44.90
70+	$70.30

11. CRITICAL ILLNESS INSURANCE – SPOUSE

Please check (✓) one box

Employees have the option of purchasing Critical Illness coverage through Guardian. You may purchase coverage for your Spouse or Child(ren) in increments of $5,000 up to a maximum of $10,000.

☐ **Yes,** I wish to elect Spousal Critical Illness Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Spousal Critical Illness Coverage.

CRITICAL ILLNESS - SPOUSE

MONTHLY RATES PER $5,000 OF COVERAGE	
AGE	SPOUSE
0–29	$2.35
30–39	$3.85
40–49	$7.25
50–59	$13.55
60–69	$22.45
70+	$35.15

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the plan year, unless there is a qualified change in status under the terms of the plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through [[CLIENT NAME]] during the open enrollment period each year and during the year within 30 days of a qualified change in status.

Employee Signature: _____ **Date:** _____

This Enrollment Form template is presented for illustrative purposes. Please consult with your legal and compliance teams to ensure that all information is accurate before sharing with employees.