2023 BENEFIT ELECTION FORM

NEW HIRES: Benefit elections are effective the first of the month following 60 days of employment.

You cannot make changes outside of the initial election period or open enrollment unless you experience a qualified life event (e.g. marriage, birth of a baby, etc.) and notify Human Resources within 30 days of the event.

All benefit costs shown below are weekly costs.

Note you can also make your elections online in Ceridian.

EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Street Address	City, State, Zip

Primary Phone Number	Social Security Number
( ) -	- -

MEDICAL/PRESCRIPTION COVERAGE: Horizon Blue Cross Blue Shield of New Jersey/Express Scripts

Coverage Tier	High Deductible Health Plan (HDHP)	PPO Plan
Employee Only	☐ $21.23	☐ $67.62
Employee + Child(ren)	☐ $39.92	☐ $121.85
Employee + Spouse	☐ $49.85	☐ $152.31
Employee + Family	☐ $82.15	☐ $250.38
☐ Waive Medical Coverage		

HEALTH SAVINGS ACCOUNT *(HDHP)*

In 2023, [[CLIENT NAME]] will contribute $1,000 annually for those who enroll in the HDHP.

☐ **I would like to make a pre-tax payroll contribution to an HSA account:**

$________________ per paycheck for a total of $________________per year

*In 2022, the maximum contribution is **$3,850 for individual coverage** or **$7,750 for family coverage** (includes employee and [[CLIENT NAME]] contributions)**.** Individuals that are 55 and older can contribute an additional $1,000 per year. You can change your contribution anytime during the year through Ceridian or by contacting Human Resources.*

☐ **I do not want to contribute to an HSA account via payroll deductions.**

DENTAL COVERAGE: MetLife

Coverage Tier	
Employee Only	☐ $4.64
Employee + Child(ren)	☐ $10.77
Employee + Spouse	☐ $9.71
Employee + Family	☐ $16.51
☐ Waive Dental Coverage	

VISION COVERAGE: United Healthcare Vision

Coverage Tier	
Employee Only	☐ $0.00
Employee + Child(ren)	☐ $1.49
Employee + Spouse	☐ $1.10
Employee + Family	☐ $2.60
☐ Waive Vision Coverage	

2023 BENEFIT ELECTION FORM

DEPENDENT INFORMATION

Name	Coverage	Social Security Number	Date of Birth	Sex	Relationship	Is dep. disabled?
	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		☐ Yes ☐ No
	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		☐ Yes ☐ No
	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		☐ Yes ☐ No
	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		☐ Yes ☐ No
	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female		☐ Yes ☐ No

FLEXIBLE SPENDING ACCOUNTS (FSA): Wex

HEALTH CARE FSA [[CLIENT NAME]] will contribute $500 to your Health Care FSA if you are enrolled in the PPO plan.	☐ **I would like to make a pre-tax payroll contribution to a Health Care FSA:** $________________ per paycheck for a total of $________________per year *The 2023 maximum contribution is $2,850 (includes employee and [[CLIENT NAME]] contributions). If you are enrolled in a Health Savings account, you are not eligible to elect a Health Care FSA, however, you may elect the Limited Purpose FSA (for dental and vision expenses only).* ☐ **I do not want to contribute to a Healthcare FSA via payroll deductions.**
LIMITED PURPOSE FSA	☐ **I would like to make a pre-tax payroll contribution to a Limited Purpose FSA:** $________________ per paycheck for a total of $________________per year *The 2023 maximum contribution is $2,850.* ☐ **I do not want to contribute to a Limited Purpose FSA via payroll deductions.**
DEPENDENT CARE FSA	☐ **I would like to make a pre-tax payroll contribution to a Dependent Care FSA:** $________________ per paycheck for a total of $________________per year *The 2023 maximum contribution is $5,000 (or $2,500 if married and filing separately).* ☐ **I do not want to contribute to a Dependent Care FSA via payroll deductions.**
COMMUTER REIMBURSEMENT ACCOUNTS	☐ **I elect to contribute $________ per pay period for a monthly total of $________ for public transportation.** ☐ **I elect to contribute $________ per pay period for a monthly total of $________ for parking expenses.** *The Commuter Reimbursement Accounts can help pay for eligible transit and parking expenses using pre-tax dollars. The maximum contribution for these accounts is $280 per month for public transportation and $280 per month for parking expenses.* ☐ **Waive the Commuter Reimbursement Account.**

2023 BENEFIT ELECTION FORM

VOLUNTARY LIFE COVERAGE – Symetra
Employee Voluntary Life
You may purchase employee voluntary life coverage in increments of $10,000 up to the lesser of 5 times your basic annual earnings or $500,000. Coverage over the guaranteed issue amount requires a Statement of Health form. ☐ **I elect Employee Voluntary Life Coverage in the following amount: $______________** ☐ **I decline Employee Voluntary Life Coverage**
Spouse Voluntary Life
You may purchase spouse voluntary life coverage in increments of $5,000 up to the lesser of $250,000 or 100% of employee coverage amount. Coverage over the guaranteed issue amount requires a Statement of Health form. ☐ **I elect Spouse Voluntary Life Coverage in the following amount: $______________** ☐ **I decline Spouse Voluntary Life Coverage**
Dependent Child(ren) Voluntary Life
You may purchase coverage for your dependent child(ren) in the amount of $500 if child is under 15 days old, or $10,000 if child is 15 days and older. ☐ **I elect Child Voluntary Life Coverage in the following amount: $______________** ☐ **I decline Child Voluntary Life Coverage**

By signing this form, I accept the benefit elections indicated. I understand there may be limitations on benefits or restrictions on availability of coverage in certain circumstances. I authorize the company to deduct required contributions through payroll for the above elections. I understand that I should read the subscriber certificate or benefit booklet provided to me to understand my benefits and any restrictions that apply to my health care plans. I understand that my opportunity to change my coverage will be limited to annual enrollment or a qualified life event as determined by the IRS Regulations under Section 125 of the IRS code. I understand that I am required to provide proof of said qualified change to the Human Resources representative within 30 days of a qualified life event change or I will not be eligible to make said change(s) until the next annual Open Enrollment period.

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.