

HR Use Only Annual Salary _____ Class _____ Location _____
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Benefits Enrollment Form

2021

January through December Plan Year

FOR NEW ENROLLMENTS ONLY

Employee Information

Name _____ Social Security Number _____

Date of Birth _____ Department _____ Hourly Salary Hours per week _____

Male Female Marital Status: Single Married Domestic Partner Children/Dependents

Address _____ City _____ State _____ Zip _____

Job Title _____ Date of Hire _____ Pay Level _____

Phone _____ Email _____

Spouse Name _____ M F Birth Date _____

Child Name _____ M F Birth Date _____

Child Name _____ M F Birth Date _____

Child Name _____ M F Birth Date _____

Child Name _____ M F Birth Date _____

Child Name _____ M F Birth Date _____

All prices shown below are bi-weekly payroll deductions

Medical Plan – MedCost

Waive Medical (no coverage) **Enroll in medical by checking one of the following boxes:**

<input type="checkbox"/> Employee Only – Core \$63.72	<input type="checkbox"/> Employee Only – Buy Up \$131.12
<input type="checkbox"/> Employee + Spouse – Core \$235.30	<input type="checkbox"/> Employee + Spouse – Buy Up \$395.65
<input type="checkbox"/> Employee + Child(ren) – Core \$192.51	<input type="checkbox"/> Employee + Child(ren) – Buy Up \$331.91
<input type="checkbox"/> Family – Core \$401.40	<input type="checkbox"/> Family – Buy Up \$653.97

If you are enrolling in Medical, you also need to complete MedCost’s Enrollment Form.

Dental Insurance – Guardian PPO

Waive Dental (no coverage) **Enroll in dental by checking one of the following boxes:**

- Employee Only \$6.56 Employee + Spouse \$20.89 Employee + Child(ren) \$24.88 Family \$41.42

(prices shown are bi-weekly payroll deductions)

Vision Insurance – Guardian through VSP

Waive Vision (no coverage) **Enroll in vision by checking one of the following boxes:**

- Employee Only \$1.40 Employee + Spouse \$3.92 Employee + Child(ren) \$4.20 Family \$6.84

(prices shown are bi-weekly payroll deductions)

Life Insurance – Guardian

Basic Life and Accidental Death & Dismemberment – Paid 100% by Utili-Serve – 1 times salary, up to \$150,000

Primary Beneficiary _____	Relationship _____	_____%
_____	Relationship _____	_____%
Contingent Beneficiary _____	Relationship _____	_____%
_____	Relationship _____	_____%

In addition to the Basic Life/AD&D that Utili-Serve provides, you can add up to \$200,000 of additional Voluntary Life & Accidental Death & Dismemberment coverage (payroll deductions depend on age, health, amount)

Waive Volunteer Life (no additional coverage) **Add Employee Voluntary Life / AD&D by checking the following:**

- 1 times salary 2 times salary* 3 times salary* 4 times salary* 5 times salary*

Add Voluntary Life / AD&D for Spouse – 100% of employee’s voluntary life amount*

Add Voluntary Life / AD&D for Child(ren) – 10% of employee’s voluntary life amount up to \$10,000*

Have you used any form of tobacco in the past 12 months? Employee No Yes Spouse No Yes

Disability Insurance – Guardian

Short-Term Disability (STD) – Paid 100% by Utili-Serve – 60% of salary, up to \$100/week for 13 weeks

In addition to the Short-Term Disability that Utili-Serve provides, you can add Long-Term Disability that provides 60% of your salary, up to \$6,000 per month (payroll deductions depend on age and salary)

Waive Long-Term Disability (no LTD coverage)

Add Employee Long-Term Disability*

Critical Illness Benefit – Guardian

Pays the selected lump sum for specific major medical conditions (payroll deductions depend on age and lump sum selected)

Waive Critical Illness (no coverage) **Add Critical Illness Benefit for Employee by checking amount:**

If wanted, select Lump Sum Amount: \$5,000 \$10,000* \$15,000* \$20,000* \$25,000*

Add Critical Illness for Spouse – 50% of employee lump sum*

Add Critical Illness for Child(ren) – 50% of employee lump sum*

If electing Critical Illness, have you ever been diagnosed or treated for:

1. Cancer, carcinoma, malignant melanoma, benign or malignant tumor, Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder, or any disease of the kidneys, liver, lungs, pancreas, or bone marrow? Or, been advised to have an organ, bone marrow, or stem cell transplant? Employee: Yes No Spouse: Yes No
2. Heart attack, heart disease, coronary artery disease, stroke or TIA, or been advised to have bypass surgery, stent insertion, or treatment of coronary arteries? Employee: Yes No Spouse: Yes No
3. Diabetes or uncontrolled blood pressure within 6 months? Employee: Yes No Spouse: Yes No
4. AIDS, AIDS-related complex, or tested positive for HIV? Employee: Yes No Spouse: Yes No

Accident Benefit – Guardian

Pays cash amounts for specified expenses that result from an accident (bi-weekly payroll deductions shown)

- Waive Accident (no coverage) Add Accident Benefit for Employee Only \$7.81
 Add Accident Benefit for Employee + Spouse \$12.69
 Add Accident Benefit for Employee + Child(ren) \$12.91
 Add Accident Benefit for Employee + Family \$17.79

Authorization

I authorize Utili-Serve, LLC to deduct premiums from my paychecks for the benefits I have elected above. I understand that dental, vision, and medical elections may not be changed until the next open enrollment period, unless I have a change in status as defined by IRS rules. I also understand that if I experience a qualifying or disqualifying change in status, it is my responsibility to notify Utili-Serve within 30 days of that change.

The information on this form is presented for illustrative purposes and is based on information obtained from various benefit summary plan descriptions. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancies between this form and the actual plan documents, the actual plan documents will prevail. All information herein is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this form, please contact Human Resources.

* I also understand that not all insurance coverages are guaranteed, and my elections may require me to provide additional medical information, if requested, which may determine actual coverages provided.

Printed Name _____

Employee Signature _____ Date Signed _____