2024 Benefit Election Form

Employee Name: _____ Business Entity: _____ Store Number: _____

Make your elections by checking the appropriate box for each benefit at your desired coverage level. Please list all dependents and which coverages they will be enrolled in (M, D, V, VL) on the back side. Premium amounts shown are per pay period deduction amount. Benefit deductions are taken on the first two paychecks of every month, twenty-four (24) times per year.

MEDICAL INSURANCE

**There will be a $100 per month spousal surcharge if covering a spouse who has other coverage through his/her employer sponsored plan and still chooses to be on the Arona plan.*

Wellmark - $2,000 Deductible PPO

☐ Single	$160.64
☐ Employee/Spouse	$417.65
☐ Employee/Child(ren)	$367.69
☐ Family	$666.76

Wellmark - $5,000 PPO Deductible

☐ Single	$34.02
☐ Employee/Spouse	$309.17
☐ Employee/Child(ren)	$280.14
☐ Family	$434.14

Wellmark - $2,000 Deductible HMO

☐ Single	$126.69
☐ Employee/Spouse	$348.11
☐ Employee/Child(ren)	$303.42
☐ Family	$562.56

Wellmark - $5,000 HMO Deductible

☐ Single	$29.62
☐ Employee/Spouse	$264.45
☐ Employee/Child(ren)	$224.99
☐ Family	$382.62

Wellmark - $5,000 HDHP

☐ Single	$50.83
☐ Employee/Spouse	$295.45
☐ Employee/Child(ren)	$257.35
☐ Family	$407.94

☐ I decline medical insurance for 2024.

DENTAL INSURANCE

☐ Single	$14.86
☐ Employee/Spouse	$31.09
☐ Employee/Child(ren)	$34.95
☐ Family	$54.90

☐ I decline dental coverage for 2024.

VISION INSURANCE

☐ Single	$4.87
☐ Employee/Spouse	$9.55
☐ Employee/Child(ren)	$9.84
☐ Family	$13.89

☐ I decline vision coverage for 2024.

VOLUNTARY LIFE INSURANCE

☐ I wish to apply for the Voluntary Life Insurance Plan for 2024**.**
Employee Amount: $_____
Spouse Amount: $_____
Dependent Amount: $_____
Note: Guarantee Issue amount is $100,000 for employees and $25,000 for spouses. If you are electing over this amount, you must provide Evidence of Insurability. If you were previously eligible and did not elect Voluntary Life Insurance, you must provide Evidence of Insurability regardless of amount elected.

☐ I decline to apply for the Voluntary Life Insurance Plan for 2024.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

☐ I wish to apply for the Voluntary Short-Term Disability Plan for 2024.
Employee Amount: _____
(please enter amount requested in multiple of $50, no greater than 60% of salary)

☐ I decline to apply for the Voluntary Short-Term Disability Plan for 2024.

CRITICAL ILLNESS

☐ I wish to enroll in Critical Illness for 2024.
Amount of Coverage: ☐ $15,000 ☐ $30,000

☐ I decline to enroll in Critical Illness for 2023.

☐ Single
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family

ACCIDENT

HIGH PLAN		**LOW PLAN**	
☐ Single	$11.22	☐ Single	$5.87
☐ Employee/Spouse	$17.40	☐ Employee/Spouse	$9.11
☐ Employee/Child(ren)	$20.28	☐ Employee/Child(ren)	$10.63
☐ Family	$27.02	☐ Family	$14.16

☐ I decline to enroll in Accident Coverage for 2024.

LIFELOCK IDENTITY PROTECTION

BASE PLAN		**ULTIMATE PLAN**	
☐ Single	$4.25	☐ Single	$10.63
☐ Employee/Spouse	$8.50	☐ Employee/Spouse	$21.25
☐ Employee/Child(ren)	$7.44	☐ Employee/Child(ren)	$15.41
☐ Family	$11.69	☐ Family	$26.03

☐ I decline to enroll in LifeLock Identity Theft Protection for 2024.

FLEXIBLE SPENDING ACCOUNT

☐ I wish to enroll in the Flexible Spending Account for 2024.
Healthcare Annual Amount: _____ (maximum of $3,050)
Dependent Care Annual Amount: _____ (maximum of $5,000)

☐ I decline to enroll in the Flexible Spending Account for 2024.

HEALTH SAVINGS ACCOUNT

☐ I wish to enroll in the Health Savings Account for 2024.
Annual Amount: _____

Note: Maximum amount for Single is $4,150. Maximum amount for Family is $8,300. If you have a spouse who is also contributing to an HSA, your combined total contribution cannot exceed $8,300. If you or a spouse are enrolled in the FSA, you may not put money into an HSA.

☐ I decline to enroll in the Health Savings Account for 2024.

Please list all dependents and indicate which coverages they will be enrolled in.

Employee Name	**DOB**	**SSN**	**Relationship**	**Coverage**
_____	_____	_____	Employee	_____
Spouse Name	**DOB**	**SSN**	**Relationship**	**Coverage**
_____	_____	_____	Spouse	_____
Dependent Name(s)	**DOB**	**SSN**	**Relationship**	**Coverage**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**** Please Note: You will automatically be enrolled in the Company Paid Life Insurance and Long-Term Disability. You do not need to take any action to enroll in these benefits.**

Please list a beneficiary for your employer paid Life Insurance and/or Voluntary Life Insurance.

PRIMARY BENEFICIARY

Name: _____ **Relationship:** _____

Phone: _____ **Address:** _____

SECONDARY BENEFICIARY

Name: _____ **Relationship:** _____

Phone: _____ **Address:** _____

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM:

I have indicated my benefit preferences on this and other benefit enrollment forms for the 2024 Plan Year. I understand that these changes will remain in effect until 12/31/2024, unless there is a change in my family status as defined in the plans. I authorize the Company to reduce my earnings by the amount of these elections or to take deductions for the after-tax elections. I authorize the Company to keep these elections in effect for any subsequent years, unless I provide specific written notification in accordance with plan enrollment provisions.

Print Name: _____ **Date:** _____

Signature: _____

This form is provided to you for a matter of convenience. Holmes Murphy does not represent or warrant that all categories or fields on this form adhere or comply with the requirements of any or all health insurance carriers. Any information provided by you on this form will be used to the extent allowable in the enrollment process. Holmes Murphy shall not be held liable for any incorrect information or mistakes made on this document. Holmes Murphy makes no representations or warranties as to the accuracy or completeness of the document or information input therewith. Users should always refer to any and all applicable federal, state, provincial, municipal or local laws relevant to healthcare enrollment requirements. You have the right to, and should, seek the advice of legal counsel at your own expense.

CONSENT TO RECEIVE ELECTRONIC ERISA DISCLOSURES:

****ALL EMPLOYEES MUST COMPLETE AND RETURN TO HUMAN RESOURCES****

Name: _____ Email: _____

Employee Address: _____ City: _____ State: _____ Zip: _____

I understand that:

1. The following documents and/or notices may be provided to me electronically:
   - Summary Plan Descriptions
   - Summaries of Material Modifications
   - Summary Annual Reports
   - COBRA Notices
   - Summary of Benefits Coverage
   - Notice of Health Insurance Marketplace Coverage Options
   - CHIPRA Notices
2. I may provide notice of a revised email address or revoke my consent at any time without charge by notifying Human Resources at (515) 225-9029.
3. I am entitled to request and obtain a paper copy of any electronically furnished document free of charge by contacting Human Resources at (515) 225-9029.
4. In order to access information provided electronically, I must have:
   - A computer with Internet access
   - An email account that allows me to send and receive emails
   - Microsoft Word or Adobe Acrobat Reader

☐ I consent to receive these documents electronically.

☐ I DO NOT consent to receive these documents electronically.

Signature: _____ Date: _____