MODERN

2020 Benefit Election Form

LIVE WELL. CHOOSE WELL.

Print Employee Name _____ Last four digits of Social Security number _____

Address_____ Phone _____

Personal email address _____

Medical Insurance

☐ **Elect Coverage** ☐ **Decline Coverage** Myself and applicable dependents have other health insurance yes ☐ no ☐

GOLD 126		SILVER 7100		BRONZE 8100	
☐ Employee Only	$65.92	☐ Employee Only	$26.00	☐ Employee Only	$18.09
☐ Family ___EE&SP ___EE & Ch	$249.61	☐ Family ☐ EE&SP ☐ EE&Ch	$109.81	☐ Family ☐ EE&SP ☐ EE&Ch	$69.77

Dental Insurance

☐ **Elect Coverage** ☐ **Decline Coverage**

GOLD		SILVER		BRONZE	
☐ Employee Only	$5.48	☐ Employee Only	$4.05	☐ Employee Only	$3.18
☐ Employee & Spouse	$11.50	☐ Employee & Spouse	$9.06	☐ Employee & Spouse	$7.12
☐ Employee & Child(dren)	$13.79	☐ Employee & Child(ren)	$11.02	☐ Employee & Child(ren)	$8.65
☐ Family	$19.85	☐ Family	$16.20	☐ Family	$12.71

Vision Insurance

☐ **Elect Coverage** ☐ **Decline Coverage**

GOLD		SILVER	
☐ Employee Only	$3.05	☐ Employee Only	$1.60
☐ Employee & Spouse	$5.13	☐ Employee & Spouse	$2.69
☐ Employee & Child(ren)	$5.23	☐ Employee & Child(ren)	$2.75
☐ Family	$8.28	☐ Family	$4.35

Health Savings Account (HSA) must be enrolled in Silver or Bronze Medical plan

☐ **Elect** ☐ **Decline**
(must have an active HSA Account)

_____ Annual contribution*
*May be changed any time during the year

2020 Max: $3,550 single coverage ($4,550 age 55 or over)
$7,100 family coverage ($8,100 age 55 or over)

Bank _____ Routing Number_____

Account Number _____

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Voluntary Term Life Insurance and AD&D (see Benefit Summary for cost)

☐ **Elect Coverage** ☐ **Decline Coverage**

☐ Employee: Amount: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000

☐ Spouse: Amount: $_____ ($5,000 - $75,000 in $5,000 increments, max of 50% of employee amount)

☐ Child Amount: $_____ ($1,000 - $10,000 in $1,000 increments)

Primary Beneficiaries: MUST LIST ONE FOR COMPANY PAID INSURANCE!

Name_____ Relationship_____ DOB_____ %_____

Name_____ Relationship_____ DOB_____ %_____

Contingent Beneficiary:

Name_____ Relationship_____ DOB_____ %_____

Voluntary Long Term Disability (see Benefit Summary for cost)

*Max 60% of monthly wage

☐ **Elect Coverage** ☐ **Decline Coverage**

Amount: ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500

☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000

Voluntary Short Term Disability (see Benefit Summary for cost)

*Max 60% of weekly wage

☐ **Elect Coverage** ☐ **Decline Coverage**

Weekly benefit elected: _____ ($100-$1500; increments of $50)

Voluntary Accident Insurance

☐ **Elect Coverage** Myself and applicable dependents have health insurance yes ☐ no ☐ ☐ **Decline Coverage**

GOLD		SILVER	
☐ Employee Only	$2.40	☐ Employee Only	$1.48
☐ Employee & Spouse	$3.93	☐ Employee & Spouse	$2.28
☐ Employee & Child(ren)	$3.96	☐ Employee & Child(ren)	$2.65
☐ Family	$5.48	☐ Family	$3.45

Primary Beneficiaries:

Name_____ Relationship_____ DOB_____ %_____

Name_____ Relationship_____ DOB_____ %_____

Contingent Beneficiary:

Name_____ Relationship_____ DOB_____ %_____

Voluntary Critical Illness (see Benefit Summary for cost)

☐ **Elect Coverage** ☐ **Decline Coverage**

☐ Employee
Coverage Amount: ☐ $15,000 ☐ $30,000

☐ Spouse
Coverage Amount ☐ $15,000 ☐ $30,000 ☐ Child? Y/N (cost included in employee amount)

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Dependents

Spouse:
Name_____ M ☐ F ☐ SS#_____ DOB_____

Child 1:
Name_____ M ☐ F ☐ SS#_____DOB_____

Child 2:
Name_____ M ☐ F ☐ SS#_____ DOB_____

Child 3:
Name_____ M ☐ F ☐ SS#_____ DOB_____

Child 4:
Name_____ M ☐ F ☐ SS#_____ DOB_____

Child 5:
Name_____ M ☐ F ☐ SS#_____ DOB_____

Acknowledgement

I make this Benefits Deduction Authorization voluntarily and knowingly. I affirm that the deductions the Company will make under this Benefits Deduction Authorization are solely for my benefit, and not for the benefit or convenience of the Company in any way.

I understand that this Benefits Deduction Authorization can be changed at any time by submitting a Benefits Deduction Authorization Form to Human Resources. I further understand that I can revoke this Benefits Deduction Authorization at any time by submitting written notice of revocation to Human Resources. I understand that changes to and/or revocation of this Benefits Deduction Authorization may impact my benefits if it causes me to make insufficient contributions to fund my share of the applicable premium(s).

Unless or until this Benefits Deduction Authorization is revoked or changed, the Company is authorized to take deductions according to it, including during any leave of absence that I may take. In the event I take any leave of absence that is unpaid in whole or part, I will make arrangements to pay the Company directly for my share of all applicable premiums for any benefits that are continued during the leave of absence. If I fail to make payments to the Company during my leave of absence that are sufficient to fully cover my share of all such applicable premiums, I authorize the Company to take increased deductions from my payroll, to the maximum extent permitted by law, when I return from the leave. These increased deductions will continue until the Company fully recovers all amounts the Company paid to cover my share of all such applicable premiums during my leave of absence.

Print Employee Name _____ Employee Signature_____ Date_____