Benefits Election Form

A. INFORMATION ABOUT YOU

Employee

Date of Hire

Mailing Address

City

State

Zip Code

Home Phone

Date of Birth

Social Security Number

B. YOUR ELECTION (check the appropriate box)

Wellmark Blue Cross Blue Shield Health Insurance Options

- ◯ Decline
- ◯ Elect - PPO (Co-pay Plan)
- ◯ Elect - HDHP (High Deductible Plan)

Health Insurance Levels of Coverage

- ◯ Employee Only
- ◯ Employee + 1 Dependent
- ◯ Employee + Family

PPO Medical & Rx Bi-weekly Period Cost*

Employee Only $62.46

Employee + 1 Dependent $195.90

Employee + Family $379.33

HDHP Medical & Rx Bi-weekly Period Cost*

Employee Only $34.13

Employee + 1 Dependent $112.75

Employee + Family $221.21

Delta Dental of South Dakota

Benefit Enrollment Start Date

- ◯ Elect
- ◯ Decline

Delta Dental Levels of Coverage

- ◯ Employee Only
- ◯ Employee + 1 Dependent
- ◯ Employee + Family

Bi-weekly Cost

Employee Only $5.01

Employee + 1 Dependent $20.35

Employee + Family $26.72

Vision Plans

Vision Plans

- ◯ Elect - Materials Only
- ◯ Elect - Exam + Materials
- ◯ Decline

Levels of Coverage

- ◯ Employee Only
- ◯ Employee + 1 Dependent
- ◯ Employee + Family

Materials Only Monthly Cost

Employee Only $7.04

Employee + 1 Dependent $13.38

Employee + Family $19.64

Exam + Materials Monthly Cost

Employee Only $10.93

Employee + 1 Dependent $20.77

Employee + Family $30.49

By selecting the coverage choice(s) above, I authorize my employer to deduct from my paycheck any required contributions on a pre-tax basis as permitted by IRS code Section 125 from my earnings as my contribution toward the cost of these programs.

By signing below, I understand that I am making benefit elections for the benefit enrollment period of the date mentioned below until the end of the current calendar year. Furthermore, I understand that unless I experience a life changing event, I will not be allowed to make changes to my election choices until the next open enrollment period.

Your Signature

Today's Date

Benefit Enrollment Start Date

D. DEPENDENT INFORMATION FOR MEDICAL, DENTAL, AND VISION

Only Eligible Dependents can be covered.

Check here if you have more dependents than you can list below. Provide all requested information on a separate sheet and attache...

☐

Dependent 1 Name (First, Middle Initial, Last)

Dependent 1 SSN

Dependent 1 Sex

◯ Female

◯ Male

Dependent 1 Relationship

Dependent 1 Birthdate

If over age 26, is your child disabled?

Enrolled in the following coverage(s)

☐ Medical

☐ Dental

☐ Vision

If this Dependent has a Different Address Than You List it Here

Dependent 2 Name (First, Middle Initial, Last)

Dependent 2 SSN

Dependent 2 Sex

◯ Male

◯ Female

Dependent 2 Relationship

Date of Birth

If over age 26, is your child disabled?

Enrolled in the following coverage(s)

☐ Medical

☐ Dental

☐ Vision

If this Dependent has a Different Address Than You List it Here

Dependent 3 Name (First, Middle Initial, Last)

Social Security Number

Dependent 3 Sex

◯ Male

◯ Female

Dependent 3 Relationship

Dependent 3 Birthdate

If over age 26, is your child disabled?

Enrolled in the following coverage(s)

- [ ] Medical
- [ ] Dental
- [ ] Vision

If this Dependent has a Different Address Than You List it Here