



## 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 \$55.88  
Employee + 1 Dependent \$172.52  
Employee + Family \$334.24

#### HDHP Medical & Rx Bi-weekly Period Cost\*

Employee Only \$34.51  
Employee + 1 Dependent \$111.50  
Employee + Family \$217.59

Delta Dental of South Dakota

Delta Dental of South Dakota

- Elect  
 Decline

Delta Dental Levels of Coverage

- Employee Only  
 Employee + 1 Dependent  
 Employee + Family

#### Bi-weekly Cost

Employee Only \$4.75  
Employee + 1 Dependent \$19.25  
Employee + Family \$25.25

Avesis Vision Plans

Avesis Vision Plans

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

Avesis Levels of Coverage

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

**Materials Only Monthly Cost**

- Employee Only \$10.51
- Employee + 1 Dependent \$18.39
- Employee + Family \$27.32

**Exam + Materials Monthly Cost**

- Employee Only \$13.78
- Employee + 1 Dependent \$24.12
- Employee + Family \$35.83

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