Return this completed form to Human Resources

Benefit Election, Waiver Form and Beneficiary Form

Please complete the following election form for your 2021-2022 benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Motherboard Express Systems and are therefore waiving all coverage, please check the box for waiving all coverage. If waiving all coverage, complete only the top section of the form and sign/date at the bottom of the back page.

☐ **Open Enrollment** ☐ **New Hire** ☐ **Change of Status *** ☐ **Waiving All Coverage ****

***Qualifying Life Event:** _____

**Change of Status is only applicable if you have experienced a qualifying life event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*

Company Name: Casa Central

Employee Name (Please Print): _____

Address: _____

Date of Birth: ___/___/___ Gender: _____

Social Security #: ___—___—___

Location: _____

Coverage Effective: ___/___/___

Date of Hire: ___/___/___

City, State, Zip Code: _____

Telephone Number: ___—___—___

Marital Status: _____

Hourly / Salary (Circle One): $ _____

Medical Coverage — BlueCross BlueShield

Election	H.S.A Select	HMO*	H.S.A	Blue Choice Options PPO
Employee Only	☐ $48.56	☐ $102.58	☐ $124.58	☐ $169.88
Employee + Spouse	☐ $166.95	☐ $273.72	☐ $335.62	☐ $406.77
Employee + Child(ren)	☐ $87.93	☐ $175.62	☐ $209.26	☐ $284.87
Family	☐ $206.32	☐ $346.76	☐ $420.30	☐ $521.77

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section on the next page.

☐ **I choose to waive medical coverage for myself and my dependents**

***For HMO elections ONLY:** A Primary Care Physician (PCP) SELECTION IS REQUIRED - BE SURE TO COMPLETE THE PCP INFORMATION ON NEXT PAGE

Waiving Coverage - Authorization and Signature

I choose to waive Medical coverage for myself and my dependents. I understand that if I waive coverage, I will not be able to enroll until the next Open Enrollment period or until I experience a Qualifying Life Event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact Human Resources within 30 days of the life status change. You must provide a reason for waiving medical coverage.

Signature: _____ Reason for waiving: _____

Voluntary Dental Coverage — UNUM

Election	Low PPO	High PPO
Employee Only	☐ $10.28	☐ $21.75
Employee + One	☐ $20.04	☐ $43.00
Family	☐ $27.10	☐ $68.93

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section on the next page.

☐ **I choose to waive dental coverage for myself and my dependents**

Voluntary Vision Coverage — VSP

Election	Vision
Employee Only	☐ $3.17
Employee + Spouse	☐ $5.07
Employee + Child(ren)	☐ $5.17
Family	☐ $8.34

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section on the next page.

☐ **I choose to waive vision coverage for myself and my dependents**

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision
	– –	/ /			☐	☐	☐
	– –	/ /			☐	☐	☐
	– –	/ /			☐	☐	☐
	– –	/ /			☐	☐	☐

*PCP Information *(if electing in the HMO plan)*

Name of Enrolled	Medical PCP Name & Number	Medical Group Name & Number

Basic Life/AD&D Coverage — This benefit is Employer Paid

UNUM provides a Basic Life/AD&D benefit to all eligible employees of $20,000. Please list below the beneficiaries that you wish to have on file:

UNUM

Primary Beneficiary Full Name	Address	Date of Birth	Relationship to Employee	Benefit Percentage
		/ /		%
		/ /		%
		/ /		%
Total (must equal 100%)				%

Contingent Beneficiary Full Name	Address	Date of Birth	Relationship to Employee	Benefit Percentage
		/ /		%
		/ /		%
		/ /		%
Total (must equal 100%)				%

Voluntary Life/AD&D Coverage

UNUM

Election **Waive**

☐ I choose to elect voluntary life/AD&D coverage (indicate coverage amount below) ☐ I am choosing to waive voluntary life/AD&D coverage

I understand that I will be responsible for paying the full cost of the premium for this benefit.

Type of Benefit	Benefit Amount Offered	Guarantee Issue Amount *	Life Coverage Elected	AD&D Coverage Elected
Employee	Elect up to 5x salary not to exceed $500,000 in $10,000 increments	$200,000	$	$
Spouse	Elect up to 5x salary not to exceed $500,000 in $5,000 increments	$25,000	$	$
Child(ren)	Elect a maximum of $10,000 in $1,000 increments	$10,000	$	$

** Evidence of insurability applies to any amount of life coverage elected over the guarantee issue amount, but does not apply to AD&D coverage*

Rate Table

Age Band	Employee/Spouse Life Rate per $1,000	Age Band	Employee/Spouse Life Rate per $1,000
15-24	$0.080 / $0.127	**50-54**	$0.510 / $712
25-29	$0.080 / $0.122	**55-59**	$0.880 / $1.077
30-34	$0.080 / $0.150	**60-64**	$1.190 / $1.529
35-39	$0.120 / $0.201	**65-69**	$2.050 / $2.144
40-44	$0.190 / $0.301	**70-74**	$4.83 / $4.058
45-49	$0.310 / $0.478	**75+**	$18.35 / $12.542

Child Life Monthly Rate
$0.40 per $1,000

Employee & Spouse AD&D Rate per $1.000	Child AD&D Rate per $1,000
$0.02	$0.025

NOTE: *You must complete the **Evidence of Insurability** form if (1) You previously waived or did not enroll when you first became eligible; (2) You have elected to purchase more than **$100,000** for Employee Coverage; (3) You have elected to purchase more than **$25,000** for Spouse Coverage; (4) you have elected to purchase any amount of coverage for your child(ren) that previously waived or did not enroll when you first became eligible. You must purchase coverage for yourself in order to purchase coverage for your spouse and/or child(ren). Late entrants and amounts over the Guarantee Issue are subject to underwriting approval. Coverage will begin on the first of the month following approval. In some instances, a physical exam by a doctor may be required. The rate for dependent children is $0.170 per $1,000 of coverage, and covers all eligible children.*

Voluntary Short Term Disability

UNUM

Waiting Period	Benefit	How to Calculate
Coverage begins on the 8th day of continuous illness or injury	60% of earnings with a maximum weekly benefit of $1,000 for a duration of 12 weeks	(STD): (Weekly Benefit-60% or earnings* x Rate) / 10 = Monthly Premium *= Up to maximum benefit

Age Band	Rate per $10	Age Band	Rate per $10
12-24	$1.16	50-54	$1.10
25-29	$1.57	55-59	$1.22
30-34	$1.67	60-64	$1.47
35-39	$1.21	65-69	$1.78
40-44	$0.99	70+	$1.78
45-49	$0.98		

☐ **I choose to elect Voluntary STD**

☐ **I choose to waive Voluntary STD**

Voluntary Long Term Disability

UNUM

Waiting Period	Benefit	How to Calculate
Coverage begins on the 91st day of continuous illness or injury	60% of earnings with a maximum monthly benefit of $1,000 until SSNRA	(LTD): (Monthly Earnings* x Rate / 100 = LTD Monthly Premium *= Up to maximum benefit

Age Band	Rate per $100	Age Band	Rate per $100
12-24	$0.22	50-54	$2.39
25-29	$0.35	55-59	$2.92
30-34	$0.63	60-64	$2.94
35-39	$0.96	65-69	$2.59
40-44	$1.53	70+	$2.15
45-49	$1.97		

☐ **I choose to elect in Voluntary LTD**

☐ **I choose to waive Voluntary LTD**

Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes will be during the October 2021 open enrollment period for an 11/1/2021 effective date, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact Human Resources within 30 days of the life status change.

My signature below authorizes Casa Central to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: ____/____/____