YOUR HEALTH. YOUR SAFETY.
Strengthening Our Community Together

Benefit Election, Waiver Form and Beneficiary Form

Please complete the following election form for your 2025 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 Casa Central 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	Coverage Effective	
Employee Name *(Please Print)*		Date of Hire	
Address		City, State, Zip Code	
Date of Birth	Gender	Telephone Number	
Social Security #		Marital Status	
Location		Hourly / Salary *(Circle One)*	$

Medical Coverage (per paycheck) — BlueCross BlueShield

Election	HDHP/HSA (Select)	HDHP/HSA (PPO)	Blue Advantage HMO
Employee Only	☐ $40.00	☐ $102.95	☐ $98.80
Employee + Spouse	☐ $156.50	☐ $295.26	☐ $263.16
Employee + Child(ren)	☐ $78.75	☐ $188.05	☐ $169.14
Family	☐ $190.00	☐ $376.53	☐ $333.74

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section on the 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 (per paycheck) — Humana

Election	Low PPO Per Paycheck	High PPO Per Paycheck
Employee Only	☐ $9.55	☐ $20.20
Employee + One	☐ $20.53	☐ $44.73
Family	☐ $30.93	☐ $69.32

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 (per paycheck) — EyeMed

Election	Vision per paycheck
Employee Only	☐ $2.86
Employee + Spouse	☐ $4.57
Employee + Child(ren)	☐ $4.67
Family	☐ $7.53

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

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

BlueCross BlueShield

Election **Waive**

☐ I choose to elect Voluntary Life/AD&D coverage (indicate coverage amount below)
I understand that I will be responsible for paying the full cost of the premium for this benefit.

☐ I am choosing to waive Voluntary Life/AD&D coverage

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 $2,000 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*

Monthly 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 / $0.712
25-29	$0.080 / $0.122	**55-59**	$0.880 / $1.000
30-34	$0.080 / $0.150	**60-64**	$1.190 / $1.077
35-39	$0.120 / $0.201	**65-69**	$2.050 / $1.529
40-44	$0.190 / $0.301	**70-74**	$4.830 / $2.144
45-49	$0.310 / $0.478	**75+**	$18.35 / $12.542

Child Life Rate per $2,000
$0.800

Employee & Spouse AD&D Rate per $1,000	Child AD&D Rate per $2,000
$0.020	$0.050

NOTE: *You must complete the **Evidence of Insurability** form if:*
For Annual Enrollment evidence of insurability is required – For those currently enrolled increasing greater than (1) increment of $10,000 up to the guarantee issue amount of $200,000 (applies to employee coverage only). Any amount above the guarantee issue amount requires evidence of insurability. For those without current coverage, evidence of insurability is required.

Voluntary Short Term Disability

BlueCross BlueShield

Waiting Period	Benefit
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

Your Premium Calculation

(Enter your salary and the rate for your current age from the table)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium	x 12 ÷ 24 =	Semi-Monthly Premium
$ ÷ 52	=	$	x	$0.60	=	$	x	$	=	$	x 12 ÷ 24 =	$

Monthly Rate per $10 of Weekly Benefit	
Age	Rate
Under 20	$0.986
20-24	$0.986
25-29	$1.335
30-34	$1.420
35-39	$1.029
40-44	$0.842
45-49	$0.833
50-54	$0.935
55-59	$1.037
60-64	$1.250
65+	$1.513

☐ **I choose to elect Voluntary STD**

☐ **I choose to waive Voluntary STD**

Voluntary Long Term Disability

BlueCross BlueShield

Waiting Period	Benefit
Coverage begins on the 91st day of continuous illness or injury	60% of earnings with a maximum monthly benefit of $6,000 until SSNRA

Your Premium Calculation

(Enter your salary and the rate for your current age from the table)

Monthly Earnings (maximum $10,000)	x	Rate *(from table above)*	=	Amount ÷ 100	=	Monthly Premium	x 12 ÷ 24 =	Semi-Monthly Premium
$	x	$	=	$ ÷ 100	=	$	x 12 ÷ 24 =	$

Monthly Rate per $100 of Covered Payroll	
Age	Rate
Under 20	$0.187
20-24	$0.187
25-29	$0.298
30-34	$0.536
35-39	$0.816
40-44	$1.301
45-49	$1.675
50-54	$2.032
55-59	$2.482
60-64	$2.499
65-69	$2.202
70+	$1.828

☐ **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 for the 2026 enrollment period which will be in November or December of 2025 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: _____

* You agree that by typing your name it is the equivalent of your manual signature.

SUBMIT