Benefit Election Form

Plan Year: April 1, 2021 – March 31, 2022

A. Employee Information

Last Name	First Name	MI	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated
Street Address	City	State	Zip Code	County

Home Phone ( )	Work Phone ( )	Date of Birth	Date of Hire	Hours Worked/Week
Social Security Number		SS Disabled ☐ Yes ☐ No	Medicare Enrolled ☐ Yes ☐ No	Annual Earnings
Email Address				

B. HEALTH PLAN with Vision & Dental Coverage BCBS Texas & Guardian

There is no separate election for health, vision, or dental coverage. Health coverage includes vision and dental coverage.

☐ **WAIVE** ☐ **ELECT – *Complete the following:***

Coverage Status – Indicate who is covered:

- ☐ Employee Only
- ☐ Employee + One family member*
- ☐ Employee + Two or more family members*

Indicate your tobacco status:

- ☐ Non-Tobacco User – A signed *Non-tobacco Affidavit Form* is required.
- ☐ Tobacco User

*If you will insure your Spouse/Children, please complete Section C. ▶

- At the time of your effective date with the BCBS Health Plan, will you, your spouse, or dependent(s) be insured by any other health insurance company? ☐ YES ☐ NO If YES, check type: ☐ Group Plan ☐ Individual Plan
- Do all plan enrollees above live at the same address as the employee? ☐ YES ☐ NO If NO, list name and address:

  _____
- If any dependent age 26 or older is disabled, please write name and type of disability. This dependent may be eligible for guaranteed coverage.

  _____

C. Family Members to be Covered – Health, Vision & Dental Plans Use Extra Paper if Necessary. Go to Section D if not enrolling.

Relation	Last Name	First Name	MI	Gender	Social Security Number	Date of Birth mm/dd/yyyy	Indicate if FT Student, SS Disabled, or Medicare Enrolled
Spouse				☐ M ☐ F			
☐ Child ☐ Stepchild				☐ M ☐ F			
☐ Child ☐ Stepchild				☐ M ☐ F			
☐ Child ☐ Stepchild				☐ M ☐ F			
☐ Child ☐ Stepchild				☐ M ☐ F			
☐ Child ☐ Stepchild				☐ M ☐ F			

Please complete Page 2 ▶

D. BASIC LIFE and AD&D PLAN – *Employer Paid* Sun Life ☑ ELECT

All eligible employees receive $30,000 of Basic Life/AD&D coverage through Sun Life.

WL Plastics pays the premiums for this plan. You are automatically enrolled if you are eligible.
Indicate your beneficiaries in Section F below.

E. VOLUNTARY LIFE / AD&D PLAN Sun Life

☐ **WAIVE** ☐ **ELECT - *Indicate enrollment below.***

☐ I wish to elect Voluntary Life/AD&D.
Enter totals below. If none, enter $0:

	Term Life	**AD&D***
Employee:	**$** _____	**$** _____
Spouse:	**$** _____	**$** _____
Child/ren:	**$** _____	**$** _____

Employee must be enrolled to insure a spouse/children.

These guaranteed Term Life insurance amounts are available only when you are first eligible for this plan:

- Employee: Up to $150,000 ($10,000 increments)
- Spouse: Up to $30,000 ($5,000 increments)
- Child/ren: $5,000 or $10,000

If you apply for coverage over the guaranteed amounts, please complete the Sun Life Evidence of Insurability Form. Contact HR for forms.

* Accidental Death and Dismemberment (AD&D) does not require evidence of insurability. It is available as a separate benefit.

F. BENEFICIARY DESIGNATIONS – For Voluntary Life/AD&D and Basic Life/AD&D plan proceeds. Use Extra Paper if Necessary.

Beneficiary Name Indicate Primary or Contingent	**Address**	**Date of Birth** mm/dd/yyyy	**Relationship to Employee**	**Benefit Percentage** Totals must equal 100%
☐ **Primary** ☐ **Contingent**				Basic Life: _____ Vol Life: _____
☐ **Primary** ☐ **Contingent**				Basic Life: _____ Vol Life: _____
☐ **Primary** ☐ **Contingent**				Basic Life: _____ Vol Life: _____

G. DISABILITY PLANS – *Employer Paid* Sun Life ☑ ELECT

WL Plastics pays the premiums for these plans. You are automatically enrolled if you are eligible.

- **Short-term Disability (STD:** All eligible employees receive STD coverage.
- **Basic Long-term Disability (LTD):** All eligible employees receive Basic LTD coverage.

H. Optional DISABILITY (LTD) BUY-UP PLAN Sun Life

☐ **WAIVE** ☐ **ELECT**

- This plan is paid by you through payroll deductions if you enroll. It can provide additional long-term disability (LTD) benefits equal to 60% of earnings up to $12,000/month maximum.
- When you are first eligible for this plan, your enrollment is guaranteed. Enrolling at a later date requires evidence of insurability.

I. FLEXIBLE SPENDING PLAN Alerus

☐ **WAIVE** ☐ **ELECT - *Complete the following:***

I wish to participate in one or both Flexible Spending Accounts (FSAs). *Indicate amounts below. If none, enter $0.*

☐ **Medical FSA:** $_____ per pay period *OR* $_____ annual amount.
(Maximum is $2,750/year)

☐ **Dependent Care FSA:** $_____ per pay period *OR* $_____ annual amount.
(Maximum is $5,000/year if single or married filing jointly or $2,500 if filing separately)

Please complete Page 3 ▶

J. AUTHORIZATION and SIGNATURE: *Please sign and date this form.*

Benefit changes/enrollments are permitted only 1.) as a new hire or newly benefit-eligible employee and within your eligibility period, 2.) during the annual open enrollment period, or 3.) if you have a qualifying life event. The next open enrollment period occurs in March of 2022 for a benefit effective date of April 1, 2022. Qualifying life events include loss of other coverage, job status change, marriage, divorce, legal separation, birth, adoption, ceasing to be a dependent child, and other events as prescribed by law. If you or your family experience a qualifying life event, please contact WL Plastics within 30 days of the event.

I authorize WL Plastics to deduct applicable insurance premiums from my earnings.

X _____ _____ _____

Employee Name (print) | Employee Signature | Date

For questions, please contact:

Ashley Sayles
Human Resources
WL Plastics
ashley.sayles@wlplastics.com
(682) 831-2704