

Mainland Abhe & Svoboda, Inc.

2023 – 2024 Benefits Enrollment

Employee Information – Print clearly

First Name:	Last Name:	M.I.:	Social Security #:	Telephone:
Address:			City:	State: Zip:
Birth Date:	Date of Hire:	Gender:	Marital Status:	Email Address:

Dependent Information (Please enter dependent information and check the benefits(s) in which you wish to enroll each dependent)

Name (First, M.I., Last)	Sex	Date of Birth	Relationship	Social Security #	Medical	Dental	Dep. Life	Vision
Spouse/domestic partner:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Insurance – Blue Cross Blue Shield of MN



Group # 211857

Your Election

	RATES		(Please CHECK One)
	ASI/Trust Pays	EE Pays	
Medical Employee Only (Mandatory for Prevailing Wage Employees)	\$ 1,029.00	\$ 0.00	<input type="checkbox"/>
Employee + Spouse/domestic partner	\$ 1,029.00	\$ 1,132.00	<input type="checkbox"/>
Employee + Child(ren)	\$ 1,029.00	\$ 720.50	<input type="checkbox"/>
Family	\$ 1,029.00	\$1,749.50	<input type="checkbox"/>

By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.

Dental Insurance – Delta Dental

Group # 127237

Your Election

	RATES		(Please CHECK One)
	ASI/Trust Pays	EE Pays	
Dental Employee Only	\$ 19.25	\$ 19.25	<input type="checkbox"/>
Employee + Spouse/domestic partner	\$ 24.50	\$ 59.50	<input type="checkbox"/>
Employee + Child(ren)	\$ 31.20	\$ 62.80	<input type="checkbox"/>
Family	\$ 39.70	\$ 99.30	<input type="checkbox"/>

By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.

Employee Name:

Vision Insurance – EyeMed			
Group # 1011257		RATES	<u>Your Election</u> <small>(Please CHECK One)</small>
Vision	Employee Only	\$ 8.14	<input type="checkbox"/>
	Employee + Spouse/Domestic Partner	\$ 15.46	<input type="checkbox"/>
	Employee + Child(ren)	\$ 16.27	<input type="checkbox"/>
	Family	\$ 23.92	<input type="checkbox"/>
By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.			

Voluntary Short-Term Disability – The Standard	Premium RATE For Office Use Only
Elect <input type="checkbox"/> Employee Short Term Disability	
Statutory Coverage -- Employees eligible for statutory coverage (NJ, CA, HI, RI and PR) cannot elect this plan as the state/statutory plan offers benefits greater than or equal to this plan.	Taxability -- Short Term Disability insurance premiums will be paid on an after-tax basis. Therefore, any benefits received will not be taxed.

By NOT electing any of the above coverages, it is assumed you are WAIVING coverage

Voluntary Short-Term Disability Insurance Rates – The Standard												
Rates are for each \$10 in coverage												
Age	< 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
STD Rate per \$10	.27	.27	.27	.27	.32	.32	.44	.44	.57	.57	.57	.57

Example: John is 46 years old at the time of application or renewal elects Short-Term Disability

$$\text{Weekly Earnings (cannot be more than \$2,500)} \times 0.60 \times \text{Rate From Table Above} \div 10 = \text{Monthly Premium}$$

$$\$2,500 \times 0.60 \times 0.32 \div 10 = \$48.00 \text{ monthly cost}$$

Basic Life, AD&D – The Standard	
Provided by Abhe & Svoboda, Inc.	Your Employee Basic Life Insurance and Accidental Death & Dismemberment Insurance premiums are paid by Abhe & Svoboda, Inc. Enrollment is automatic for those employees who meet the eligibility requirements. The benefits are as follows:
Employee Basic Life	\$10,000
Employee AD&D Benefit:	\$10,000
	Note: Life and AD&D benefits reduce by 35% at age 65 and to 50% at age 70. All coverage cancels at retirement, continuation or conversion may be available

Employee Name: _____

Voluntary Life Insurance Rates – The Standard												
Monthly Cost for Each \$1,000 of Employee & Spouse/Domestic Partner Life Insurance Coverage												
Age	< 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Life	.05	.05	.08	.09	.13	.22	.36	.59	.78	1.27	2.14	2.14
Dependent Children	\$10,000 benefit – cost is \$1.40 per month and covers all eligible dependent children.											

NOTES: Employee coverage is required to elect coverage for spouse/domestic partner or children. Combined basic & voluntary life may not exceed 8x annual earnings. Spouse/domestic partner rate is based on employee's age. Voluntary Life benefits reduce by 35% at age 65 and to 50% at age 70. All coverage cancels at retirement, continuation and/or conversion may be available. Underwriting is required if coverage was previously waived or requesting increased coverage.

Example: John is 46 years old at the time of application or renewal elects \$50,000 of Voluntary Life

$$\text{\$ Amount of Coverage} \div 1,000 \times \text{\$ Unit Cost from Above} = \text{\$ Employee Monthly Cost}$$

$$\text{\$50,000} \div 1,000 \times .22 = \text{\$11.00 monthly cost}$$

Voluntary Life – The Standard		Requested Amount Spouse/domestic partner no greater than 50% of EE	Premium RATE For Office Use Only
Elect	<input type="checkbox"/>	Employee Life	\$
Elect	<input type="checkbox"/>	Spouse/domestic partner Life	\$
Elect	<input type="checkbox"/>	Child Life	\$ 10,000
NEW HIRES ONLY: Medical History Statement Form is required for amounts over \$150,000 for employees		NEW HIRES ONLY: Medical History Statement Form is required for amounts over \$50,000 for spouse/domestic partner	Life Insurance Premiums will be paid on an after-tax basis, per IRS regulations

Life Beneficiary Information – Updates ONLY

The Employee signing below names the following person's as primary beneficiary(ies) for any payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. This designation applies to Life and/or AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. The Employee understands that he or she has the right to change this designation at any time.

Beneficiary Name (First, M.I., Last)	Relationship	Allocation (%)	Social Security #	Phone # & Address
Contingent Beneficiary	Relationship	Allocation (%)	Social Security #	Phone # & Address

Voluntary Accident Insurance – The Standard			Your Election (Please CHECK One)
	RATES		
Voluntary Accident	Employee Only	\$ 3.70	<input type="checkbox"/>
	Employee + Spouse/Domestic Partner	\$ 5.76	<input type="checkbox"/>
	Employee + Child(ren)	\$ 7.16	<input type="checkbox"/>
	Family	\$ 11.17	<input type="checkbox"/>

By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.


Employee Name: _____

Voluntary Critical Illness – The Standard			
			<u>Your Insurance Election</u> <i>(Please CHECK One)</i>
Voluntary Critical Illness	Employee Only Requested Amount	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000
	Spouse/Domestic Partner Requested Amount (Cannot exceed 50% of Employee Requested Amount)	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Note: Children are automatically covered at 50% of your coverage amount			
By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.			

Critical Illness Attained Age Monthly Premium - Employee						
	19-29	30-39	40-49	50-59	60-69	70+
\$10,000	\$3.20	\$4.60	\$8.80	\$17.70	\$32.30	\$77.80
\$20,000	\$6.40	\$9.20	\$17.60	\$35.40	\$64.60	\$155.60

Critical Illness Attained Age Monthly Premium – Spouse/Domestic Partner						
	19-29	30-39	40-49	50-59	60-69	70+
\$5,000	\$1.60	\$2.30	\$4.40	\$8.85	\$16.15	\$38.90
\$10,000	\$3.20	\$4.60	\$8.80	\$17.70	\$32.30	\$77.80

I understand the benefits and limitations of the various plans and I authorize Abhe & Svoboda, Inc. to make the necessary deductions from my pay, based on my choices. I further understand my decisions are in effect for the plan year and no changes can be made prior to the next open enrollment unless a change in status occurs. A change in status is defined by Federal law, but may include events such as, but not limited to, marriage, divorce, termination or commencement of employment for you, your spouse/domestic partner or dependents, etc. If I experience a qualifying change in status, I understand that I have 30 days to make an election change and this change must be consistent with the change in status. I understand that my deduction amount will change if my coverage costs change.

 Abhe & Svoboda, Inc. conducts periodic audits to ensure that dependents enrolled in the plan meet the eligibility criteria. Any misrepresentation or falsification of information regarding eligibility for coverage or benefits may be considered fraud and could result in (i) termination of your benefits, (ii) termination of your employment, and (iii) reimbursement to Abhe & Svoboda, Inc. of benefit that were improperly obtained.

I represent that the statements contained herein are true and complete, to the best of my knowledge and belief.

Employee Signature

Date

Employee Printed Name

FOR OFFICE USE ONLY:

For Human Resources Purpose Only			
<input type="checkbox"/> New Hire	<input type="checkbox"/> Early Retiree	<input type="checkbox"/> Marriage	<input type="checkbox"/> COBRA
<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Divorce/Legal separation	<input type="checkbox"/> Termination/Reduction in work hours	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Death	<input type="checkbox"/> Special Enrollment – Date: _____	
<input type="checkbox"/> Retiree	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Other: _____	
Date of event: _____			
_____ Employer Signature		_____ Date	