HAWAII 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:		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:					☐	☐	☐	☐
Child:					☐	☐	☐	☐
Child:					☐	☐	☐	☐
Child:					☐	☐	☐	☐
Child:					☐	☐	☐	☐

Health Insurance – UHA Health Insurance

Group # 211857

		RATES ASI/Trust Pays	RATES EE Pays	Your Election (Please CHECK One)
Medical	Employee Only (Mandatory for Prevailing Wage Employees)	$ 473.12	$ 0.00	☐
	Employee + Spouse/domestic partner	$ 473.12	$ 554.02	☐
	Employee + Child(ren)	$ 473.12	$ 450.87	☐
	Family	$ 473.12	$ 946.22	☐

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

Dental Insurance – Delta Dental Network

Group # 127237

		RATES ASI/Trust Pays	RATES EE Pays	Your Election (Please CHECK One)
Dental	Employee Only	$ 19.25	$ 19.25	☐
	Employee + Spouse/domestic partner	$ 24.50	$ 59.50	☐
	Employee + Child(ren)	$ 31.20	$ 62.80	☐
	Family	$ 39.70	$ 99.30	☐

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

Employee Name:

Vision Insurance – EyeMed

Group # 1011257

		RATES	Your Election *(Please CHECK One)*
Vision	Employee Only	$ 8.14	☐
	Employee + Spouse/Domestic Partner	$ 15.46	☐
	Employee + Child(ren)	$ 16.27	☐
	Family	$ 23.92	☐

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

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.

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	.050	.050	.080	.090	.130	.220	.360	.590	.780	1.270	2.140	2.140
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.*
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.
Underwriting is required if coverage was previously waived.

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

$ Amount of Coverage ÷ 1,000 x $ Unit Cost from Above = $ Employee Monthly Cost

$50,000 ÷ 1,000 *x* .22 = $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*
	Employee Life	**$**	
	Spouse/domestic partner Life	**$**	
	Child Life	**$ 10,000**	**$ 1.40 All Children**
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

Employee Name:

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 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 – The Standard

			Your **Insurance** Election
		RATES	***(Please CHECK One)***
Voluntary Accident	Employee Only	$ 3.70	☐
	Employee + Spouse/Domestic Partner	$ 5.76	☐
	Employee + Child(ren)	$ 7.16	☐
	Family	$ 11.17	☐

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

Voluntary Critical Illness – The Standard

		Your **Insurance** Election	
		(Please CHECK One)	
Voluntary Critical Illness	Employee Only Requested Amount	☐ $10,000	☐ $20,000
	Spouse/Domestic Partner Request Amount (Cannot Exceed 50% of Employee Requested Amount)	☐ $5,000	☐ $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						
	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

Employee Name:

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

- ☐ New Hire
- ☐ Late Enrollment
- ☐ Open Enrollment
- ☐ Retiree
- ☐ Early Retiree
- ☐ Divorce/Legal separation
- ☐ Death
- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Termination/Reduction in work hours
- ☐ Special Enrollment – Date: _____
- ☐ Other: _____
- ☐ COBRA

Date of event: _____

Employer Signature _____ Date _____