BENEFITS ENROLLMENT APPLICATION
January 1, 2019 – December 31, 2019 Plan Year

Please Print Clearly or Type. Use Blue or Black Ink.			
Last Name:	First Name:	Middle:	Social Security No:
Marital Status ☐ Single ☐ Married	Birth Date ___/___/_____	Gender: ☐ Male ☐ Female	Date of Hire ___/___/_____
Street Address:	City:	State:	Zip Code:
Cell Phone No:	Email:		

Check the coverage level you are enrolling in for 2019. Your effective date is 1st of the month following 30 days after your hire date.

1. Medical

Flex Plan	If Earning under $65,000		If Earning between $65,000 and $85,000		If Earning between Over $85,000		HSA Plan**	All Salary Levels	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly		Weekly	Bi-Weekly
☐ Employee Only	29.37	58.74	48.94	97.89	88.10	176.20	☐ Employee Only	69.23	138.46
☐ Employee + Spouse/DP	129.21	258.43	193.82	387.64	215.36	430.71	☐ Employee + Spouse/DP	207.69	415.38
☐ Employee + Child(ren)	90.55	181.10	126.77	253.54	162.99	325.98	☐ Employee + Child(ren)	138.45	276.90
☐ Employee + Family	178.86	357.72	250.60	501.19	344.57	689.14	☐ Employee + Family	184.64	369.28

☐ I am declining **medical** coverage. Reason: _____

****If you participate in the HDHP, and you are not covered by any other medical plan, you may set aside tax-free dollars in an HSA, not to exceed the IRS statutory maximum of $3,500 Individual / $7,000 Family for calendar year 2019. Your HSA contributions will come out pre-tax from your paycheck, and you may change your election amount throughout the year. You may be required to contact WageWorks to complete the process to open your HSA account once you receive your welcome materials.**

Please indicate the amount you elect to set aside for Health Savings Account weekly or bi-weekly per-pay check contribution amount here: $_____

2. Dental – Provided by Guardian

Managed DentalGuard MDG Plan	Weekly	Bi-Weekly	Buy-up NAP Plan	Weekly	Bi-Weekly
☐ Employee Only	3.26	6.52	☐ Employee Only	6.52	13.04
☐ Employee + Spouse/DP	5.16	10.32	☐ Employee + Spouse/DP	14.04	28.08
☐ Employee + Child(ren)	7.07	14.14	☐ Employee + Child(ren)	15.66	31.32
☐ Employee + Family	8.40	16.79	☐ Employee + Family	23.18	46.37

☐ I am declining **Dental** coverage.

3. Vision – Provided by Guardian

Vision Plan	Weekly	Bi-Weekly
☐ Employee Only	1.52	3.04
☐ Employee + Spouse/DP	2.56	5.12
☐ Employee + Child(ren)	2.61	5.22
☐ Employee + Family	4.13	8.26

☐ I am declining **Vision** coverage.

4. Employer-Paid Basic Life

Basic Life & AD&D Insurance	☒ Paid by ***Western Extrusions*** *Must complete life beneficiary designation on page 3.*	Amounts vary based on length of Service, beginning after 2 years

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	Employee-Paid Voluntary Life
	Voluntary Life: **You:** Amounts in $25,000 increments to the lesser of 3x annual salary or $250,000 **Your Spouse/DP:** Amounts in $12,500 increments up to 50% of the employee life amount **Your Child(ren):** Amounts in $2,500 increments to the lesser of 10% of the employee life amount or $10,000
	Voluntary Life Guaranteed Issue Amounts The guaranteed issue is the amount of voluntary insurance that you may elect when first eligible without providing medical evidence of insurability. **You:** $250,000*. **Your Spouse:** $50,000* **Your Child(ren):** $10,000 *Amounts greater will require medical evidence of insurability
	Please note, employees must enroll in voluntary life and AD&D benefits in order to enroll their spouse or child in coverage. **Must complete life beneficiary designation on page 3.**
5.	**I elect for Voluntary Life for myself in the amount of $_____** ☐ I am declining employee **Voluntary Life** coverage.
6.	**I elect for Voluntary life for my spouse in the amount of $_____** ☐ I understand that I must enroll in voluntary life coverage in order to enroll my spouse in coverage ☐ I am declining employee **Voluntary Spouse Life** coverage.
7.	**I elect for Voluntary Child Life in the amount of $_____** ☐ I understand that I must enroll in employee Voluntary Life coverage in order to enroll my spouse in coverage. ☐ I am declining spouse **Voluntary Child Life** coverage.
	Evidence of Insurability (EOI): This is your new hire enrolment opportunity to elect coverage without completion of a medical evidence of insurability for amounts up to the guarantee issue (GI). If you waive the right to enroll at this time, you will be subject to EOI if you elect to enroll after your 31-day eligibility period. If you elect above the guarantee issue amount, please complete an EOI with your application. You will be covered as of your effective date for any amounts up to the GI until underwriting has made a determination on your elected amounts.

Weekly EE & Sp Voluntary Life Rates / $1,000 in Coverage

Under 30	$.016
30-34	$.018
35-39	$.023
40-44	$.042
45-49	$.076
50-54	$.120
55-59	$.198
60-64	$.282
65-69	$.487
70-75	$.727
75+	$1.327

Bi-Weekly EE & Sp Voluntary Life Rates / $1,000 in Coverage

Under 30	$.032
30-34	$.037
35-39	$.046
40-44	$.083
45-49	$.152
50-54	$.240
55-59	$.397
60-64	$.563
65-69	$.974
70-75	$1.454
75+	$2.654

Short Term Disability Premium Table - Weekly Paycheck Deduction Amounts
Sample Rates - Your Deduction is based on your own Annual Earnings

Age	Rate	$20,000	$25,000	$30,000	$35,000	$40,000	$50,000	$60,000	$70,000	$80,000	$100,000
All	0.2169	$5.01	$6.26	$7.51	$8.76	$10.01	$10.85	$10.85	$10.85	$10.85	$10.85

Short Term Disability Premium Table - Bi-Weekly Paycheck Deduction Amounts **Sample**
Rates - Your Deduction is based on your own Annual Earnings

Age	Rate	$20,000	$25,000	$30,000	$35,000	$40,000	$50,000	$60,000	$70,000	$80,000	$100,000
All	0.4338	$10.01	$12.51	$15.02	$17.52	$20.02	$21.69	$21.69	$21.69	$21.69	$21.69

8.	**Guardian Short Term Disability**
	Voluntary Short-Term Disability: ☐ I elect Voluntary Short-Term Disability ☐ I am declining Short Term Disability coverage.

9.

Flexible Spending Accounts

Please refer to materials provided to confirm your understanding of these accounts. IRS rules strictly control your ability to discontinue or change these contributions, and unused funds may be forfeited.

Account Type	**Limited Purpose FSA**	**Healthcare FSA**	**Dependent Care FSA**
Eligibility for Account	Only Employees electing the UHC $3,500 HSA Plan	Employees electing the HMO or POS Medical Plan or No Medical Coverage	All Benefits Eligible Employees
Annual Limit for 2019	$2,700	$2,700	$5,000 ($2,500 if married filing separately)
Annual Election	Please indicate the annual amount you elect for a Limited Purpose FSA here: $_____	Please indicate the annual amount you elect for a Healthcare FSA here: $_____	Please indicate the annual amount you elect for a Dependent Care FSA here: $_____

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Covered Dependent Information for Benefits						
Last Name	First Name	MI	Social Security #	Date of Birth	Gender ☐ M ☐ F	Relationship ☐ Spouse ☐ Domestic Partner (DP)
Last Name	First Name	MI	Social Security #	Date of Birth	Gender ☐ M ☐ F	Relationship ☐ Child ☐ Student
Last Name	First Name	MI	Social Security #	Date of Birth	Gender ☐ M ☐ F	Relationship ☐ Child ☐ Student
Last Name	First Name	MI	Social Security #	Date of Birth	Gender ☐ M ☐ F	Relationship ☐ Child ☐ Student
Last Name	First Name	MI	Social Security #	Date of Birth	Gender ☐ M ☐ F	Relationship ☐ Child ☐ Student
Last Name	First Name	MI	Social Security #	Date of Birth	Gender ☐ M ☐ F	Relationship ☐ Child ☐ Student

Life Insurance Beneficiary

Applicable to Basic Life and any Employee Voluntary Life amounts elected and approved. If you elect Voluntary Life coverage for your spouse and/or children, you as the employee are the beneficiary for those elected and approved amounts.

Primary Beneficiary Name Percent of Benefit: _____	Relationship	Street Address	City	State	Zip Code
Secondary Beneficiary #1 Name Percent of Benefit*: _____	Relationship	Street Address	City	State	Zip Code
Secondary Beneficiary #2 Name Percent of Benefit*: _____	Relationship	Street Address	City	State	Zip Code

*Primary Benefit percentage and total of Secondary Benefit percentages should each equal 100%.

I understand, agree, and represent that I have read this entire application for coverage and indicated "elect or decline" on each line of coverage. This application is completed to the best of my knowledge and belief and is true and complete. I understand that if there is any intentionally false statements, misrepresentations, or omissions contained here, my coverage could be reduced, denied or, or voided. I further authorize my employer to deduct from my earnings the contributions (if any) elected above. I understand the coverage becomes effective on the 1st of the month following 30-days from my date of hire.

I understand that the benefits which I elect under the Section 125 Plan (medical, dental, vision, and flexible spending) will remain in effect for the entire plan year. I understand that my employee contributions will be deducted on a pre-tax basis from each of my paychecks to pay for the coverage that I elect that are included under Section 125.

I consent to the electronic disclosure of all Employee Benefit notices, including Medicare Part D Creditable/Non-Creditable Coverage, Women's Cancer Rights, Newborns Act and Children's Health Insurance Protection Act (where applicable), Summary Plan Descriptions, plan documents, plan amendments and any other benefit notices.

Employee Signature: _____ **Date:** _____