Master P	lans									
	Enrollment/Change							Plan Year - 08/	01/23-07/31/24	
Effective Date:										
Employee Name (Last, First, Middle Initial)			Social Security Number			Date of Bir	th	Marital Status		
Address (Maggar)	<u> </u>		Di N	.1		L. P. T. A.	0	☐ Single	☐ Married	
Address (Mailing))		Phone Nun	ıber		Job Title /	Occupation	Salary		
City State and 7	·	E Moil	A ddwoon			Candom	Wooldy House	Data of Hivo		
City, State and Zi	p	E-Mail	Address			Gender: M / F	Weekly Hours	Date of Hire		
Enrollment (Chec	k One if it applies)	Change (Check On	e if it applies)			Family Status Cha	nge (Check One if i	t applies)	
I `	lment Period	☐ Change Add		,	☐ Change Name		☐ Add Depend	•		
☐ New Hire		☐ Add Depend	ent(s)		☐ Insurance Conti	_ ' _ '				
☐ Rehire/Rein	nstatement	☐ Cancel Depe	endent(s)		☐ Waive/Drop		oing Coverage			
☐ Acquisition		☐ Waive/Drop	ping Coverage	e						
						1		Relationship: - Must	Gender	
								be legal spouse or child to be eligible	Circle One	
Action	Dependent Last Name	Firs	t Name		Date of Birth	Social S	Security Number	child to be engible		
☐ Enroll										
☐ Add								Self	M/F	
☐ Change										
☐ Enroll										
☐ Add								Spouse	M/F	
☐ Change										
☐ Enroll										
☐ Add								Child	M/F	
☐ Change										
☐ Enroll										
☐ Add								Child	M/F	
☐ Change										
		,	*	* MEI	DICAL **					
MEC 1	☐ Employee Only	☐ Employee + Spouse		☐ Employee + Child(ren)		☐ Employee + Family				
	\$83.00 per month	\$103.00 per	month \$103.		03.00 per month	\$103.00 per month				
MEC 2	☐ Employee Only	☐ Employee + Spouse ☐		□ E1	mployee + Child(ren)	☐ Employee + Family				
MEC 2	\$95.85 per month	\$145.59 per	month	\$136.17 per month		\$189.82 per month				
MEC 3	☐ Employee Only	☐ Employee	+ Spouse	Spouse		☐ Employee + Family				
	\$146.75 per month	\$231.24 per	month	1th \$215.24 per m		\$306.30 per month				
MEC 4	☐ Employee Only	☐ Employee	/ee + Spouse		mployee + Child(ren)			☐ Decline Coverage		
	\$210.44 per month	\$361.81 per	r month \$3		329.77 per month \$496.56 per month		5.56 per month			
Ternian Basic	☐ Employee Only	☐ Employee + 1		☐ Employee & Family			1			
Busic	\$83.18 per month	\$182.76 per month			\$265.84 per month			1		
Ternian	☐ Employee Only	☐ Employee + 1			☐ Employee & Family					
Choice	\$177.25 per month	\$381.91 per month			\$556.43 per month					
Ternian Max	☐ Employee Only	☐ Employee + 1			☐ Employee & Family					
Terman wax	\$271.89 per month	\$581.39 per month			\$850.52 per month					
				* * D F	NTAL **					
	☐ Employee Only	☐ Employee			mployee + Child(ren)	□ Fn	nployee + Family			
	\$19.73 per month	Employee + Spouse [\$52.65 per month			\$52.65 per month \$52.65 per month					
Cigna HMO	Primary choice for dental office Secondary choice for dental office						-			
	If you do not choose a dental office, one will be assigned to you. Assignments can be changed during the plan year.									
MetLife PPO	☐ Employee Only	☐ Employee		1	nployee + Child(ren)	i	nployee + Family	1		
Low	\$30.00 per month	\$61.08 per	•		77.45 per month		35 per month	☐ Declin	e Coverage	
MetLife PPO	☐ Employee Only	☐ Employee			nployee + Child(ren)		nployee + Family	1		
High	\$39.58 per month	\$80.49 per	-		98.52 per month		0.37 per month			
MetLife	☐ Employee Only	 			mployee + Child(ren)	_	nployee + Family	1		
Premier	\$53.00 per month				31.91 per month		.34 per month			

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MetLife Los		Employee Nan	ne (Last, First, Middle Initi	ial)							
MeLife High	MetLife Life St.2.1 per month St.2.8 per month St.2.5 per mont				* * V I	SION * *					
MeLife High	MetLife 11 Employee State MetLife 12 Exceptions S13.05 per month S13.05 p		☐ Employee Only	☐ Employee + Spouse	□ E ₁	mployee + Child(ren)	☐ En	nployee + Family			
Declare Coverage Declare Coverage Employee + Child(ren) Employee + Family Declare Coverage		MetLife Low									
S12.55 per month S22.19 per month S23.10 per month S25.13 per month	S23.59 permonth S23.59 permonth S23.519 permonth S23.513 permonth		-	•				_		Decline Coverage	
MetLife	MetLife	MetLife High		1 1			J				
MetLife	MetLife		\$12.55 per month	\$23.19 per monun)	21.30 per month	\$33	.13 per montn			
MetLife	MetLife										
MetLife	MetLife										
MetLife	MetLife			* * V O L U N	NTAR	Y LIFE/AD&D	* *				
MetLife	Metl ife		_	Please refe	r to rate	chart in Benefit Guid	le				
NetLife	MetLife	MotI ife	☐ Elect EMPLOYEE Life Amount Equal to								
		Witten	(You must also complete th	ne MetLife enrollment form to	secure t	his benefit.)					
Countries also complete the MetLife caroliment form to secure this benefit. Cost =	NetLife	MotI ifo								D 1: C	
Cost = Decline Coverage	Cost	WietElle	(You must also complete th							Decline Coverage	
Cost = Decline Coverage	Cost	MotI ifo	☐ Elect CHILD Life Amo	ount Equal to				Cont			
Please refer to rate chart in Benefit Guide	Please refer to rate chart in Benefit Guide	Methie	(You must also complete t	he MetLife enrollment form to	secure t	this benefit.)		Cost –			
Please refer to rate chart in Benefit Guide	Please refer to rate chart in Benefit Guide										
Please refer to rate chart in Benefit Guide	Please refer to rate chart in Benefit Guide										
Please refer to rate chart in Benefit Guide	Please refer to rate chart in Benefit Guide			* * CHOP	7 F B S		(7 d. d.				
Affac	Cost Decline Coverage										
Decline Coverage Decline Coverage	Cost	A 61		r lease rele	i to rate	Chart in Bellent Guid	ie	1			
Employee Only	Affac Employee Only Employee & Spouse Employee & Child(ren) S13.07 per month S22.71 per month S13.40 per month S41.04 per month Decline Coverage		☐ Elect Disability Monthly	y Benefit of				Cost =		Decline Coverage	
Employee Only Employee & Spouse Employee & Child(ren) Employee & Family	Affact	Disability		·							
Employee Only Employee & Spouse Employee & Child(ren) Employee & Family	Affact										
Employee Only Employee & Spouse Employee & Child(ren) Employee & Family	Affact										
Signature Sign	Second			*	* A C C	IDENT **					
Section Sect	Affac	Aflac	☐ Employee Only	☐ Employee & Spouse	□Е	mployee & Child(ren)	☐ Em	ployee & Family			
Affac Hospital S37.16 per month S73.26 per month S62.84 per month S98.94 per month Decline Coverage	Employee Only Employee & Spouse Employee & Child(ren) Employee & Family S98.94 per month S98.94	Accident	\$13.07 per month	\$22.71 per month	:	\$31.40 per month	\$41	.04 per month	Ш	Decline Coverage	
Affac Hospital	Employee Only Employee & Spouse Employee & Child(ren) Employee & Family S98.94 per month S98.94										
Affac Hospital	Employee Only Employee & Spouse Employee & Child(ren) Employee & Family S98.94 per month S98.94										
Affac Hospital	Employee Only Employee & Spouse Employee & Child(ren) Employee & Family S98.94 per month S98.94			** 11.00			* *				
S37.16 per month	S37.16 per month		D. Emmlorros Only					mlayea & Family			
Employee \$5,000	Employee \$5,000		1 1			• •				Decline Coverage	
Employee \$5,000 Employee \$10,000 Employee \$15,000 Employee \$20,000	Employee \$5,000 Employee \$10,000 Employee \$10,000	поѕрна	\$57.10 per montil	\$/3.20 per monui	Þ	φυ2.04 pci montii		\$98.94 per monui		- C	
Employee \$5,000 Employee \$10,000 Employee \$15,000 Employee \$20,000	Employee \$5,000 Employee \$10,000 Employee \$10,000										
Employee \$5,000 Employee \$10,000 Employee \$15,000 Employee \$20,000	Employee \$5,000 Employee \$10,000 Employee \$10,000										
Age 18-29	Age 18-29			* * C R I	TICA	LILLNESS **					
S3.46 per month	S3.46 per month S5.40 per month S7.34 per month S9.28 per month Age30-39		Employee \$5,000	Employee \$10,000	Eı	nployee \$15,000	Emp	oloyee \$20,000			
Age 30-39	Age 30-39		☐ Age 18-29	☐ Age 18-29		☐ Age 18-29		Age 18-29			
\$4.95 per month \$8.38 per month \$11.82 per month \$15.25 per month	\$4.95 per month Age 40-49		\$3.46 per month	\$5.40 per month	\$	7.34 per month	\$9.	28 per month			
\$4.95 per month \$8.38 per month \$11.82 per month \$15.25 per month	\$4.95 per month		☐ Age30-39	☐ Age 30-39		☐ Age 30-39		Age 30-39			
Age 40-49	Age 40-49		\$4.95 per month	\$8.38 per month		=	1	-			
\$8.44 per month \$15.36 per month \$22.28 per month \$29.19 per month Age 50-59	\$8.44 per month \$15.36 per month \$22.28 per month \$29.19 per month Age 50-59		☐ Age 40-49	-			П	Age 40-49			
Age 50-59	Age 50-59	1				•	1	•			
\$15.30 per month \$29.09 per month \$42.87 per month \$56.66 per month	S15.30 per month \$29.09 per month \$42.87 per month \$56.66 per month Age 60+	ŀ	_	-							
Aflac Critical Illness Age 60+ S27.84 per month S54.15 per month S80.41 per month S106.78 per month	Aflac Critical Illness □ Age 60+ □ A				i	_					
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Illness Spouse \$5,000 Spouse \$7,500 Spouse \$10,000 ☐ Age 18-29 ☐ Age 18-29 ☐ Age 18-29 \$3.46 per month \$4.43 per month \$5.40 per month ☐ Age 30-39 ☐ Age 30-39 ☐ Age 30-39 \$4.95 per month \$6.67 per month \$8.38 per month ☐ Age 40-49 ☐ Age 40-49 ☐ Age 40-49 \$8.44 per month \$11.90 per month \$15.36 per month ☐ Age 50-59 ☐ Age 50-59 ☐ Age 50-59 \$15.30 per month \$22.20 per month \$29.09 per month	Spouse \$5,000 Spouse \$7,500 Spouse \$10,000 ☐ Age 18-29 ☐ Age 18-29 ☐ Age 18-29 \$3.46 per month \$4.43 per month \$5.40 per month ☐ Age 30-39 ☐ Age 30-39 ☐ Age 30-39 \$4.95 per month \$6.67 per month \$8.38 per month ☐ Age 40-49 ☐ Age 40-49 ☐ Age 40-49 \$8.44 per month \$11.90 per month \$15.36 per month ☐ Age 50-59 ☐ Age 50-59 ☐ Age 50-59 \$15.30 per month \$22.20 per month \$29.09 per month ☐ Age 60+ ☐ Age 60+ ☐ Age 60+		_	ļ		•		-			
Age 18-29	Age 18-29		_	=	\$			-		Decline Coverage	
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\$8.44 per month \$11.90 per month \$15.36 per month □ Age 50-59 □ Age 50-59 □ Age 50-59 \$15.30 per month \$22.20 per month \$29.09 per month	\$8.44 per month \$11.90 per month \$15.36 per month ☐ Age 50-59 ☐ Age 50-59 \$15.30 per month \$22.20 per month \$29.09 per month ☐ Age 60+ ☐ Age 60+ ☐ Age 60+		\$4.95 per month	\$6.67 per month		\$8.38 per month					
□ Age 50-59 □ Age 50-59 □ Age 50-59 \$15.30 per month \$22.20 per month \$29.09 per month	□ Age 50-59 □ Age 50-59 \$15.30 per month \$22.20 per month □ Age 60+ □ Age 60+ Age 50-59 \$29.09 per month □ Age 60+ □ Age 60+		☐ Age 40-49			☐ Age 40-49					
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\$15.30 per month \$22.20 per month \$29.09 per month	\$15.30 per month \$22.20 per month \$29.09 per month □ Age 60+ □ Age 60+ □ Age 60+	1				•					
	□ Age 60+ □ Age 60+	1	_				_				
TO THE APPLIED TO A POPULATION OF THE POPULATION				_							
	I 547.04 DELIMORRI I 940.73 DELIMORRI I 304.10 DELIMORRI I		\$27.84 per month	\$40.99 per month			_				

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	DEC	CLINE BENEFITS	
☐ I acknowledge that I have b (Title 1, Sec 1512, 1513)	been made aware of health insurance opti	ions offered by my employer, that i	neet the minimum essential coverage requirements.
	nimum Essential Coverage (MEC) benefi	it is NOT a major medical plan and	that it only covers select preventative services.
Waiver (refusal of coverage): I a Pinnacle and I proclaim that I wa	cknowledge that I have been given the c	opportunity to apply for group cover, the writing agent, or any carrier	rage available to me and my dependents through representative into waiving (declining) coverage.
I decline to apply for group coverag	e because of:		
☐ Spousal Coverage	☐ Individual Coverage	☐ Medicare Supplement	☐ Other:
COMPLET	TE DECLINE 🛧 (OR ENROLL ↓	BUT NOT BOTH!
	ENRO	OLL IN BENEFITS	
☐ I acknowledge that I have I (Title 1, Sec 1512, 1513)	peen made aware of health insurance opti	ions offered by my employer, that i	neet the minimum essential coverage requirements.
☐ I acknowledge that the Mir	nimum Essential Coverage (MEC) benefi	it is NOT a major medical plan and	that it only covers select preventative services.
	Employee Signature - Req	uired for enrollment and/or decl	nation
this plan. I have read, or have hak howledge. I understand that if I may lose coverage under this plathis plan. I understand that my s explanation regarding my option amounts towards the purchase o year of 08/01/23 to 07/31 is not necessarily limited	In read to me, all information contained in have made a material false statement, in an I also understand that those who propalary will be reduced in accordance to the sunder the Section 125 Cafeteria Plan. If the benefits elected above. I acknow (24, has begun unless there is a to): changes in marital status,	in this form and such information in insrepresentation or omission on the vide services to me under this plane e plan guidelines if payroll deduction I understand that I have the right to ledge that my pre-tax elect change in Family Status. Changes regarding dependents	o release relevant information or medical records to a accurate and complete to the best of my is form that changes the risk assumed by this plan I are not agents, representatives or employees of ons are necessary. Furthermore, I understand the have my employer redirect my salary and apply ions cannot be changed once the plan A change in family status includes (but ents, changes in employment status, and to satisfy the eligibility conditions for
Print Name (La	ast, First, Middle Initial)		
`	,		

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Signature

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Date