Master Plans

Consolidated Enrollment/Change **Plan Year - 08/01/25-07/31/26**

Effective Date:

Employee Name (Last, First, Middle Initial)	**Social Security Number**	**Date of Birth**	**Marital Status** ☐ Single ☐ Married
Address (Mailing)	**Phone Number**	**Job Title / Occupation**	**Salary**
City, State and Zip	**E-Mail Address**	**Gender:** M / F **Weekly Hours**	**Date of Hire**

Enrollment (Check One if it applies)
- ☐ Open Enrollment Period
- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ Acquisition

Change (Check One if it applies)
- ☐ Change Address
- ☐ Add Dependent(s)
- ☐ Cancel Dependent(s)
- ☐ Waive/Dropping Coverage
- ☐ Change Name
- ☐ Insurance Continuation

Family Status Change (Check One if it applies)
- ☐ Add Dependent(s)
- ☐ Cancel Dependent(s)
- ☐ Waive/Dropping Coverage

Action	Dependent Last Name	First Name	Date of Birth	Social Security Number	**Relationship:** - Must be legal spouse or child to be eligible	**Gender** Circle One
☐ Enroll ☐ Add ☐ Change					Self	M / F
☐ Enroll ☐ Add ☐ Change					Spouse	M / F
☐ Enroll ☐ Add ☐ Change					Child	M / F
☐ Enroll ☐ Add ☐ Change					Child	M / F

** MEDICAL **

Tres Health MV Plan Core $0	☐ Employee Only $471.26 per month	☐ Employee + Spouse $812.51.00 per month	☐ Employee + Child(ren) $704.38 per month	☐ Employee + Family $1080.23 per month	☐ Decline Coverage
Tres Health MV Plan Prime $2500	☐ Employee Only $628.19 per month	☐ Employee + Spouse $1164.86 per month	☐ Employee + Child(ren) $1004.81 per month	☐ Employee + Family $10560.41 per month	
MEC 1	☐ Employee Only $83.00 per month	☐ Employee + Spouse $103.00 per month	☐ Employee + Child(ren) $103.00 per month	☐ Employee + Family $103.00 per month	
MEC 2	☐ Employee Only $97.85 per month	☐ Employee + Spouse $147.59 per month	☐ Employee + Child(ren) $138.17 per month	☐ Employee + Family $191.82 per month	
MEC 3	☐ Employee Only $131.75 per month	☐ Employee + Spouse $253.00 per month	☐ Employee + Child(ren) $253.00 per month	☐ Employee + Family $368.00 per month	
MEC 4	☐ Employee Only $195.44 per month	☐ Employee + Spouse $383.57 per month	☐ Employee + Child(ren) $367.53 per month	☐ Employee + Family $558.26 per month	
Ternian Basic	☐ Employee Only $86.22 per month	☐ Employee + 1 $181.06 per month	☐ Employee & Family $260.18 per month		
Ternian Choice	☐ Employee Only $175.81per month	☐ Employee + 1 $370.72 per month	☐ Employee & Family $536.93 per month		
Ternian Max	☐ Employee Only $265.94 per month	☐ Employee + 1 $560.68 per month	☐ Employee & Family $817.02 per month		

Employee Name (Last, First, Middle Initial) _____

** DENTAL **

MetLife PPO Low	☐ Employee Only $34.27 per month	☐ Employee + Spouse $62.53 per month	☐ Employee + Child(ren) $77.41 per month	☐ Employee + Family $113.68 per month	☐ Decline Coverage
MetLife PPO High	☐ Employee Only $42.98 per month	☐ Employee + Spouse $80.17 per month	☐ Employee + Child(ren) $96.56 per month	☐ Employee + Family $143.70 per month	
MetLife Premier	☐ Employee Only $55.18 per month	☐ Employee + Spouse $104.97 per month	☐ Employee + Child(ren) $126.92 per month	☐ Employee + Family $190.04 per month	

* VISION *

MetLife Low	☐ Employee Only $15.01 per month	☐ Employee + Spouse $23.07 per month	☐ Employee + Child(ren) $20.61 per month	☐ Employee + Family $29.43 per month	☐ Decline Coverage
MetLife High	☐ Employee Only $17.91 per month	☐ Employee + Spouse $28.90 per month	☐ Employee + Child(ren) $25.52 per month	☐ Employee + Family $37.55 per month	

* VOLUNTARY LIFE/AD&D *

MetLife	☐ Elect **EMPLOYEE** Life Amount Equal to _____ **(You must also complete the MetLife enrollment form to secure this benefit.)**	Cost = _____	☐ Decline Coverage
MetLife	☐ Elect **SPOUSE** Life Amount Equal to _____ **(You must also complete the MetLife enrollment form to secure this benefit.)**	Cost = _____	
MetLife	☐ Elect **CHILD** Life Amount Equal to _____ **(You must also complete the MetLife enrollment form to secure this benefit.)**	Cost = _____	

** SHORT TERM DISABILITY **

Please refer to rate chart in Benefit Guide

Aflac Disability	☐ Elect Disability Monthly Benefit of _____	Cost = _____	☐ Decline Coverage

**ACCIDENT **

Aflac Accident	☐ Employee Only $20.07 per month	☐ Employee & Spouse $29.71 per month	☐ Employee & Child(ren) $38.40 per month	☐ Employee & Family $48.04 per month	☐ Decline Coverage

HOSPITAL INDEMNITY

Aflac Hospital	☐ Employee Only $44.16 per month	☐ Employee & Spouse $80.26 per month	☐ Employee & Child(ren) $69.84 per month	☐ Employee & Family $105.94 per month	☐ Decline Coverage

** CRITICAL ILLNESS **

	Employee $5,000	**Employee $10,000**	**Employee $15,000**	**Employee $20,000**	
Aflac Critical Illness	☐ Age 18-29 $10.20 per month	☐ Age 18-29 $12.00 per month	☐ Age 18-29 $13.76 per month	☐ Age 18-29 $15.56 per month	☐ Decline Coverage
	☐ Age30-39 $11.56 per month	☐ Age 30-39 $14.72 per month	☐ Age 30-39 $17.92 per month	☐ Age 30-39 $21.08 per month	
	☐ Age 40-49 $14.80 per month	☐ Age 40-49 $21.16 per month	☐ Age 40-49 $27.56 per month	☐ Age 40-49 $33.96 per month	
	☐ Age 50-59 $21.12 per month	☐ Age 50-59 $33.84 per month	☐ Age 50-59 $46.56 per month	☐ Age 50-59 $59.28 per month	
	☐ Age 60+ $32.68 per month	☐ Age 60+ $57.00 per month	☐ Age 60+ $81.28 per month	☐ Age 60+ $105.56 per month	

** CRITICAL ILLNESS **

	Spouse $5,000	**Spouse $10,000**	**Spouse $15,000**	**Spouse $20,000**	
Aflac Critical Illness	☐ Age 18-29 $10.20 per month	☐ Age 18-29 $12.00 per month	☐ Age 18-29 $13.76 per month	☐ Age 18-29 $15.56 per month	☐ Decline Coverage
	☐ Age30-39 $11.56 per month	☐ Age 30-39 $14.72 per month	☐ Age 30-39 $17.92 per month	☐ Age 30-39 $21.08 per month	
	☐ Age 40-49 $14.80 per month	☐ Age 40-49 $21.16 per month	☐ Age 40-49 $27.56 per month	☐ Age 40-49 $33.96 per month	
	☐ Age 50-59 $21.12 per month	☐ Age 50-59 $33.84 per month	☐ Age 50-59 $46.56 per month	☐ Age 50-59 $59.28 per month	
	☐ Age 60+ $32.68 per month	☐ Age 60+ $57.00 per month	☐ Age 60+ $81.28 per month	☐ Age 60+ $105.56 per month	

DECLINE BENEFITS

☐ I acknowledge that I have been made aware of health insurance options offered by my employer, that meet the minimum essential coverage requirements. (Title 1, Sec 1512, 1513)

☐ I acknowledge that the Minimum Essential Coverage (MEC) benefit is NOT a major medical plan and that it only covers select preventative services.

Waiver (refusal of coverage): I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through Pinnacle and I proclaim that I was not pressured or forced by my employer, the writing agent, or any carrier representative into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I decline to apply for group coverage because of:

☐ **Spousal Coverage** ☐ **Individual Coverage** ☐ **Medicare Supplement** ☐ **Other:** _____

COMPLETE DECLINE ↑ OR ENROLL↓ BUT NOT BOTH!

ENROLL IN BENEFITS

☐ I acknowledge that I have been made aware of health insurance options offered by my employer, that meet the minimum essential coverage requirements. (Title 1, Sec 1512, 1513)

☐ I acknowledge that the Minimum Essential Coverage (MEC) benefit is NOT a major medical plan and that it only covers select preventative services.

Employee Signature - Required for enrollment and/or declination

Authorization/Acknowledgement: I hereby authorize those providing services to me, or my dependents, to release relevant information or medical records to this plan. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I understand that if I have made a material false statement, misrepresentation or omission on this form that changes the risk assumed by this plan I may lose coverage under this plan. I also understand that those who provide services to me under this plan are not agents, representatives or employees of this plan. I understand that my salary will be reduced in accordance to the plan guidelines if payroll deductions are necessary. Furthermore, I understand the explanation regarding my options under the Section 125 Cafeteria Plan. I understand that I have the right to have my employer redirect my salary and apply amounts towards the purchase of the benefits elected above. **I acknowledge that my pre-tax elections cannot be changed once the plan year of 08/01/25 to 07/31/26, has begun unless there is a change in Family Status. A change in family status includes (but is not necessarily limited to): changes in marital status, changes regarding dependents, changes in employment status, changes in residence or work site, changes in work schedule, or a dependent ceasing to satisfy the eligibility conditions for coverage.**

_____

Print Name (Last, First, Middle Initial)

_____

Signature **Date**