

Pinnacle Enrollment

Consolidated Enrollment/ Changes

Plan Year - 08/01/26 to 07/31/27

Effective Date:

Employee Name		Social Security Number		Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Address (Mailing)		Phone Number		Job Title/ Occupation	Salary	
City State and Zip		Gender: M / F	Division	Hours Workded Weekly	Date of Hire	
Enrollment (Check One if it applies) <input type="checkbox"/> Open Enrollment Period <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/ Reinstatement <input type="checkbox"/> Acquisition		Change (Check One if it applies) <input type="checkbox"/> Change Address <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Cancel Dependent(s) <input type="checkbox"/> Waive/Dropping Coverage		Family Status Change (Check One if it applies) <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Cancel Depndent(s) <input type="checkbox"/> 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
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Spouse/Child	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Child	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Child	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Child	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Child	M / F

**** MEDICAL ****

MEC 1	<input type="checkbox"/> Employee Only \$83.00 per month	<input type="checkbox"/> Employee & Spouse \$103.00 per month	<input type="checkbox"/> Employee&Child(ren) \$103.00 per month	<input type="checkbox"/> Employee & Family \$103.00 per month	<input type="checkbox"/> Decline Coverage
MEC 2	<input type="checkbox"/> Employee Only \$97.85 per month	<input type="checkbox"/> Employee & Spouse \$147.59 per month	<input type="checkbox"/> Employee&Child(ren) \$138.17 per month	<input type="checkbox"/> Employee & Family \$191.82 per month	
MEC 3	<input type="checkbox"/> Employee Only \$131.75 per	<input type="checkbox"/> Employee & Spouse \$253.00 per month	<input type="checkbox"/> Employee&Child(ren) \$253.00 per month	<input type="checkbox"/> Employee & Family \$368.00 per month	
MEC 4	<input type="checkbox"/> Employee Only \$195.44 per	<input type="checkbox"/> Employee & Spouse \$383.57 per month	<input type="checkbox"/> Employee&Child(ren) \$367.53 per month	<input type="checkbox"/> Employee & Family \$558.26 per month	
TRES Core \$2500	<input type="checkbox"/> Employee Only \$471.00 per month	<input type="checkbox"/> Employee & Spouse \$812.51 per month	<input type="checkbox"/> Employee&Child(ren) \$704.38 per month	<input type="checkbox"/> Employee & Family \$1080.23 per month	
TRES Choice \$2500	<input type="checkbox"/> Employee Only \$639.50 per month	<input type="checkbox"/> Employee & Spouse \$1347.50 per month	<input type="checkbox"/> Employee&Child(ren) \$1122.50 per month	<input type="checkbox"/> Employee & Family \$1787.50 per month	

**** DENTAL ****

MetLife PPO Low	<input type="checkbox"/> Employee Only \$34.27 per month	<input type="checkbox"/> Employee & Spouse \$62.53 per month	<input type="checkbox"/> Employee&Child(ren) \$77.41 per month	<input type="checkbox"/> Employee & Family \$113.68 per month	<input type="checkbox"/> Decline Coverage
MetLife PPO High	<input type="checkbox"/> Employee Only \$42.98 per month	<input type="checkbox"/> Employee & Spouse \$80.17 per month	<input type="checkbox"/> Employee&Child(ren) \$98.56 per month	<input type="checkbox"/> Employee & Family \$150.37 per month	
MetLife Premier	<input type="checkbox"/> Employee Only \$55.18 per month	<input type="checkbox"/> Employee & Spouse \$104.97 per month	<input type="checkbox"/> Employee&Child(ren) \$126.92 per month	<input type="checkbox"/> Employee & Family \$190.04 per month	

**** VISION ****

MetLife Low	<input type="checkbox"/> Employee Only \$9.21 per month	<input type="checkbox"/> Employee & Spouse \$18.48 per month	<input type="checkbox"/> Employee&Child(ren) \$15.65 per month	<input type="checkbox"/> Employee & Family \$25.79 per month	<input type="checkbox"/> Decline Coverage
MetLife High	<input type="checkbox"/> Employee Only \$12.55 per month	<input type="checkbox"/> Employee & Spouse \$25.19 per month	<input type="checkbox"/> Employee&Child(ren) \$21.30 per month	<input type="checkbox"/> Employee & Family \$35.13per month	

**** VOLUNTARY LIFE/AD&D ****

Please refer to rate chart in Benefit Guide

MetLife	<input type="checkbox"/> Elect EMPLOYEE Life Amount Equal to _____ (You must also complete the MetLife enrollment form to secure this benefit.)	Cost = _____	<input type="checkbox"/> Decline Coverage
MetLife	<input type="checkbox"/> Elect SPOUSE Life Amount Equal to _____ (You must also complete the MetLife enrollment form to secure this benefit.)	Cost = _____	<input type="checkbox"/> Decline Coverage
MetLife	<input type="checkbox"/> Elect CHILD Life Amount Equal to _____ (You must also complete the MetLife enrollment form to secure this benefit.)	Cost = _____	<input type="checkbox"/> Decline Coverage

**** SHORT TERM DISABILITY ****

Please refer to rate chart in Benefit Guide

Aflac Disability	<input type="checkbox"/> Elect Disability Monthly Benefit of _____	Cost = _____	<input type="checkbox"/> Decline Coverage
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**** ACCIDENT ****

Aflac Accident	<input type="checkbox"/> Employee Only \$20.07 per month	<input type="checkbox"/> Employee & Spouse \$29.71 per month	<input type="checkbox"/> Employee&Child(ren) \$38.40 per month	<input type="checkbox"/> Employee & Family \$48.04 per month	<input type="checkbox"/> Decline Coverage
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**** HOSPITAL INDEMNITY ****

Aflac Hospital	<input type="checkbox"/> Employee Only \$44.16 per month	<input type="checkbox"/> Employee & Spouse \$80.26 per month	<input type="checkbox"/> Employee&Child(ren) \$69.84 per month	<input type="checkbox"/> Employee & Family \$105.94 per month	<input type="checkbox"/> Decline Coverage
Axis Basic	<input type="checkbox"/> Employee Only \$86.22 per month	<input type="checkbox"/> Employee + 1 \$181.06 per month	<input type="checkbox"/> Employee & Family \$260.18 per month	<input type="checkbox"/> Decline Coverage	
Axis Choice	<input type="checkbox"/> Employee Only \$175.81 per month	<input type="checkbox"/> Employee + 1 \$370.72 per month	<input type="checkbox"/> Employee & Family \$536.93 per month		
Axis Max	<input type="checkbox"/> Employee Only \$265.94 per month	<input type="checkbox"/> Employee + 1 \$560.68 per month	<input type="checkbox"/> Employee & Family \$817.02 per month		

**** CRITICAL ILLNESS ****

Aflac Critical Illness	Employee \$5,000	Employee \$10,000	Employee \$15,000	Employee \$20,000	<input type="checkbox"/> Decline Coverage
	<input type="checkbox"/> Age 18-29 \$10.46 per month	<input type="checkbox"/> Age 18-29 \$12.40 per month	<input type="checkbox"/> Age 18-29 \$14.34 per month	<input type="checkbox"/> Age 18-29 \$16.28 per month	
	<input type="checkbox"/> Age 30-39 \$11.95 per month	<input type="checkbox"/> Age 30-39 \$15.38 per month	<input type="checkbox"/> Age 30-40 \$18.82 per month	<input type="checkbox"/> Age 30-39 \$22.25 per month	
	<input type="checkbox"/> Age 40-49 \$15.44 per month	<input type="checkbox"/> Age 40-49 \$22.36 per month	<input type="checkbox"/> Age 40-49 \$29.28 per month	<input type="checkbox"/> Age 40-49 \$36.19 per month	
	<input type="checkbox"/> Age 50-59 \$22.30 per month	<input type="checkbox"/> Age 50-59 \$36.09 per month	<input type="checkbox"/> Age 50-59 \$49.87 per month	<input type="checkbox"/> Age 50-59 \$63.66 per month	
	<input type="checkbox"/> Age 60+ \$34.84 per month	<input type="checkbox"/> Age 60+ \$61.15 per month	<input type="checkbox"/> Age 60+ \$87.47 per month	<input type="checkbox"/> Age 60+ \$113.78 per month	
	Spouse \$5,000	Spouse \$7,500	Spouse \$10,000		
	<input type="checkbox"/> Age 18-29 \$10.46 per month	<input type="checkbox"/> Age 18-29 \$11.43 per month	<input type="checkbox"/> Age 18-29 \$12.40 per month		
	<input type="checkbox"/> Age 30-39 \$11.95 per month	<input type="checkbox"/> Age 30-39 \$13.67 per month	<input type="checkbox"/> Age 30-39 \$15.38 per month		
	<input type="checkbox"/> Age 40-49 \$15.44 per month	<input type="checkbox"/> Age 40-49 \$18.90 per month	<input type="checkbox"/> Age 40-49 \$22.36 per month		
	<input type="checkbox"/> Age 50-59 \$22.30 per month	<input type="checkbox"/> Age 50-59 \$29.20 per month	<input type="checkbox"/> Age 50-59 \$36.09 per month		
	<input type="checkbox"/> Age 60+ \$34.84 per month	<input type="checkbox"/> Age 60+ \$47.99 per month	<input type="checkbox"/> Age 60+ \$61.15 per month		

**** 401K RETIREMENT PLAN ****

If you wish to enroll in the Retirement Plan, please contact Empower directly. You can enroll online at www.empowermyretirement.com

Employee Name (Last, First, Middle Initial) _____

ACKNOWLEDGEMENTS

- Yes** – I wish to participate in the **Pre-Tax Plan**. I authorize my employer to reduce my salary on a pre-tax basis to pay for the Medical, Dental and Vision premium for those benefits for which I have enrolled on this form.
- No** – I do not elect to participate in the **Pre-Tax Plan**. Therefore, I elect to pay for my eligible premiums on an after-tax basis outside of this Plan, and I authorize appropriate after-tax payroll deductions
- I acknowledge that the Minimum Essential Coverage (MEC) benefit is NOT a major medical plan and that it only covers select preventative services.
- I understand and agree that the medical, dental, vision and some ancillary benefits are provided through a cafeteria plan arrangement and that my share of the cost (if any) will be deducted from my pay on a pre-tax basis, reducing my taxable income. I realize that my elections will continue in effect through 07/31/26, and I can change these elections only during the annual open enrollment period or if there has been a qualifying change in my family status, employment or group healthcare coverage.

DISCLAIMER

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to the carrier.
- If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost (or if the employer stops contributing towards that coverage). However, I must request enrollment within 30 days* or any longer period that applies under the plan administrator after the other coverage ends (or after the employer stops contributing toward the other coverage).
- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days* or any longer period that applies under the plan administrator after the marriage, birth, adoption, or placement for adoption.
- If I decline enrollment for myself or for an eligible dependent (including my spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost. However, I must request enrollment within 60 days* after coverage ends under Medicaid or the state children's health insurance program.
- The carrier reserves the right to delay medical coverage and/or deny dental, basic life or voluntary life with any future application for coverage.
- If I gain eligibility for a state premium assistance subsidy through a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, I may be able to enroll myself and my dependents in this plan. However, I must request enrollment within 60 days* or any longer period that applies under the plan administrator.
- If I decline enrollment for myself or for an eligible dependent (including my spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost. However, I must request enrollment within 60 days* after coverage ends under Medicaid or the state children's health insurance program.

_____ **By initialing here, I, am waiving the opportunity to enroll in the medical plan offered by Voegtle Enterprises for the August 1, 2026 - July 31, 2027 plan year.**

EMPLOYEE SIGNATURE - Required for Enrollment and/or Waiver

Print Name (Last, First, Middle Initial)

Signature

Date