ABC Co.

200_ Health, Dental, Life, STD, LTD Insurance Open Enrollment

Benefit Election Form / Waiver Form

Employee Name: _____

Coverage: _____Elect _____Cancel _____Change

____ Yes. Please enroll me in the company-sponsored insurance plan. I authorize ***ABC Co.*** to adjust my pay as required by my election. I understand that my share of the cost will be made through payroll deductions on a ***pre-tax basis***. I understand that the benefit options I have elected will remain in force, unless I notify Human Resources in writing that I have had a change in family status within 30 days of such change. The amount listed represents my share of the insurance ***per bi-weekly pay period.*** I elect the following coverage (please circle your plan choice and your bi-weekly deduction based on your full or part time status):

The **new rates/plans are effective *MM/DD/YYYY* and are as follows:**

Medical Insurance: *XYZ Carrier* - The rates have increased *XX*%.

Plan	**Full Monthly Premium**	**Employer Cost per *Bi weekly* deduction**	**Employee Cost per *Bi weekly* deduction**
Employee	$ 000.00	$ 00.00	$00.00
Family	$0000.00	$000.00	$00.00

Dental Insurance: *XYZ Carrier* - The rates have increased *XX*%.

Plan	**Full Monthly Premium**	**Employer Cost per *Bi weekly* deduction**	**Employee Cost per *Bi weekly* deduction**
Employee	$00.00	$0.00	$0.00
Family	$00.00	$0.00	$0.00

Life AD&D, Short Term Disability, Long Term Disability: *XYZ Carrier - 100% employer paid*

***Health/Dental* Insurance Waiver:**

____**No**. I do not wish to elect coverage at this time. I understand that if I am declining enrollment for myself or my dependents including my spouse because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. Other than a qualifying event, the only other time I will be allowed to elect coverage is during the next Open Enrollment or if there is a change in my family status. A change in family status is defined as the birth of a child, adoption, marriage, divorce or death of a family member. To change coverage due to changes in family status, I understand that I only have 30 days from the date of the event to make the election or change my coverage.

Reason for Declining Coverage:

____ I Am Covered Through My Spouse's Employer.

Employer Name:_____ Insurance Carrier: _____

____ I Am Covered Under Another Group, Prepaid, Government or State Medical Plan.

____ Other

THIS FORM MUST BE RETURNED TO HUMAN RESOURCES BY *MM/DD/YYYY*.

Employee Signature: _____ Date:_____

Rates are effective from MM/DD/YYYY through MM/DD/YYYY.

Special Enrollment Rights: If an employee declines enrollment for the employee and his or her dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll in this plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.