2024-2025 Health, Dental, and Vision Benefit Enrollment Form

☐ I do not want to make any changes to my current benefits election.

(If you choose this option, you ONLY need to complete your name and sign the form)

Section 1: Employee Information			
Name (last, first)	Home Phone #	Date of Birth	Date of Hire
Street Address	Social Security #	Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Married
City, State, Zip		Hours Worked	Position/Job Title

Section 2: Enrollment		
☐ Open Enrollment	☐ New Hire	☐ Change of Status

Section 3: Benefit Plan Election(s)

Product Selection – Check all that apply. Amounts listed are semi-monthly payroll deductions (26)

Medical Plan: Anthem Silver Pathway EPO 6000/30%/9000 ☐ Employee Only – ($136.68) ☐ Employee & Spouse – ($365.67) ☐ Employee & Child(ren) – ($331.32) ☐ Employee & Family – ($560.31) ☐ **Waive Medical Coverage**	**Medical Plan: Anthem Silver Pathway EPO 4000/30%/8500** ☐ Employee Only – ($143.86) ☐ Employee & Spouse – ($380.03) ☐ Employee & Child(ren) – ($344.61) ☐ Employee & Family – ($580.78) ☐ **Waive Medical Coverage**
Medical Plan: Anthem Gold Pathway EPO 3000/40%/7300 ☐ Employee Only – ($163.84) ☐ Employee & Spouse – ($419.98) ☐ Employee & Child(ren) – ($381.56) ☐ Employee & Family – ($637.70) ☐ **Waive Medical Coverage**	**Medical Plan: Anthem Gold Pathway EPO 1500/20%/5700** ☐ Employee Only – ($172.34) ☐ Employee & Spouse – ($436.98) ☐ Employee & Child(ren) – ($397.29) ☐ Employee & Family – ($661.93) ☐ **Waive Medical Coverage**
Ameritas Dental Plan: Check One Box ☐ Employee Only – ($15.82) ☐ Employee & Spouse – ($30.41) ☐ Employee & Child(ren) – ($32.29) ☐ Employee & Family – ($51.90) ☐ **Waive Dental Coverage**	**Ameritas/VSP Vision Plan: Check One Box** ☐ Employee Only – ($3.78) ☐ Employee & Spouse – ($8.18) ☐ Employee & Child(ren) – ($6.61) ☐ Employee & Family – ($11.00) ☐ **Waive Vision Coverage**

Section 4: Dependent Information (if you require additional space, please attach separate sheet)

Name (last, first)	**Social Security #**	**Date of Birth**	**Gender**
Spouse Name			
Dependent Name and Relationship			
Dependent Name and Relationship			
Dependent Name and Relationship			

Section 5: Acknowledgement

I ACKNOWLEDGE AND AGREE TO THE FOLLOWING:

I have had an opportunity to review the descriptive materials that have been provided to me regarding this enrollment form. To the best of my knowledge, all information I have furnished is true and complete. This entire election form shall remain in effect until it is properly revoked or superseded. These elections will remain in effect during the plan year to which they apply, unless I experience a qualified status change as defined in the program. The proper and timely completion of this and other election forms is my responsibility and is essential to maintain my opportunity to participate in the program(s) and may be essential to maintain the non-taxable nature of certain program features. I authorize the claims administrator, my employer, or any organization to release any information regarding the medical and dental history, treatment, or benefits for myself or my dependents, for the purpose of reviewing treatment, validating and determining benefits, and for auditing and computing statistics. I authorize **X TEN Operations, LLC** to deduct the necessary premium(s) from my salary or wages on a pre-tax basis, unless I designate otherwise. I am not now disabled and I am performing all the duties of my occupation on a full time basis. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate or insurance booklet issued to each insured individual.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself and or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependent in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have been given the opportunity to enroll in the **X TEN Operations, LLC** voluntary insurance plans. I understand that if I decline now, but later decide to enroll, I may be required to provide Evidence of Insurability (EOI) and understand my request for coverage may be denied.

Employee Signature: _____ **Date:** _____