Benefits Confirmation Statement

Generated: June 22nd 2025

## Your Information:

**Name**
dotxc lqohx

**Gender**
M

**Employment Level**
F

**Hire Date**
2025/06/21

**Location**
SCA

**Address**

234 Ave
Bangalore, CA 90019
India

## Your Family:

| Name | Age | Gender | Relationship | QMCSO |
|---|---|---|---|---|
| odrxe eabqt | 0 | M | Child | N |

| Medical: | Coverage: | Your Cost: | Employer Cost |
|---|---|---|---|
| Blue Shield of CA - Full PPO Savings<br>Embedded Deductible 3200/5200<br>Start Date<br>odrxe eabqt (Child) | Employee + Children<br><br>06/21/2025<br>06/21/2025 | $206.59 | $334.32 |
| **Dental:** | **Coverage:** | **Your Cost:** | **Employer Cost** |
| Generic - Decline<br>Start Date<br>Termination Date | Other (DO NOT USE)<br>06/21/2025<br>06/21/2025 | $0.00 | $0.00 |
| **Voluntary Short Term Disability:** | **Status:** | **Your Cost:** | **Employer Cost** |
| Mutual of Omaha - Voluntary STD Class 1 - Omaha<br>Start Date<br>Coverage Amount | Enrolled<br><br>06/21/2025<br>$0.00 | $0.00 | $0.00 |

You have requested coverage of **$360.58**. Of this amount, **$360.58** is subject to approval. If approved, your cost will increase by **$10.82**

Employer Contribution $334.32
Your Cost Per Pay Period $206.59