MA

# Confirmation

Delta US Benefits Program

Print

## Confirmation

Your benefit elections were submitted. You can print a copy of this Confirmation page by clicking on the Print button at the top right corner of this page and then pressing Ctrl+P.

You can make changes until the day your enrollment period ends.

Currency in USD

| | |
|---|---|
| Your Total Cost Each Pay Period | 201.88 |

## Medical/Prescription

**Anthem Blue Cross PPO** 87.30
Employee Only

Who's covered?
You

## Spouse Opt Out Medical Benefit

**This plan is suspended. Complete your pending actions to resume coverage. If you need assistance, create a service request in PeopleConnect.**

Spouse Opt Out Medical Benefit

## Dental/Vision

**Delta Dental PPO**
Employee + Spouse

Who's covered?
You, Deborah Atkinson

**VSP**
Employee + Spouse

Who's covered?
You, Deborah Atkinson

## Health Savings/Flexible Spending Accounts

Waive Health Savings Account

**Health Care FSA** 114.58

Waive Dependent Care FSA

## Employee Life and AD&D

Basic Life

Primary Beneficiaries
Deborah Atkinson (100%)

Basic AD&D

Primary Beneficiaries
Deborah Atkinson (100%)

Waive Supplemental Life

Waive Supplemental AD&D

## Dependent Life

Waive Spouse Life

Waive Dependent Child Life

## Disability

Short Term Disability

Long Term Disability

## BTA/EAP

Zurich Business Travel Accident

**Managed Health Network**

## Authorization

As a Delta Dental Employee, I must comply with the below terms:

The information I am providing is accurate, and I authorize the coverage selections and the associated payroll deductions. I certify that all information is correct to the best of my knowledge, and I understand the following:

I understand that to maintain the Health Care, Limited Purpose and/or Dependent Care Flexible Spending Account and Spouse Opt Out, I must re-enroll each year.

My coverage elections cannot be revoked or modified during the year unless I experience a status change, or qualified life event as stated in the Delta Dental Summary Plan Description. I have 31 days from the status change or qualified life event to make any changes to my elections. I may, however, change my coverage elections during a future open enrollment.

I authorize my employer to deduct from my pay any required contributions owed for the coverages elected.

I hereby certify the dependents (spouse and/or children) I have enrolled in the selected coverages meet the plan eligibility rules. Dependent children ages 19-25 until they reach age 26 (or unmarried dependent children age 26 or over who became permanently and totally disabled before age 19) have this right.
**Every time I add a new dependent, I need to submit the required documentations ***

By acceptance of coverage, I authorize the Plan and others it designates including physicians, hospitals, insurance companies and service organizations, to share information about me with any medical provider, sponsoring employer or other entity, where such information is reasonably necessary for Plan administration.

**IMPORTANT** : Please ensure you add any dependents and beneficiaries on People to Cover page. This must be done in order to add them to your benefits or as a beneficiary for life insurance coverage.

**Kaiser Disclaimer**

For Kaiser Foundation Health Plan Enrollees Only:

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

| | |
|---|---|
| Employee Number<br>34081 | Name<br>Mark Atkinson |
| Date | Signature |