



08/29/2025

	Effective Date:  Deadline to Submit:										
Property Name:											
Reason for Request (c	heck one of the fol	lowing)									
☐ New Hire – Date of Hire:	Dpen Enrollr	ment $\square$	Qualifying Event	<ul><li>If so, state</li></ul>	event &	date:					
Personal Information											
Employee's Name (Last, First, MI)		Security #			Birth Date Gen		ler				
ГestEmployee, John A		5-6789			03/15/1985 M 🔀		F 🗌				
Employee's Address 23 Test Street				City Austin		State TX	Zip 78701				
Phone Number 512) 555-1234			Email Address john.test@exai				10101				
Coverage Elections (de	eductions below ar	e Bi-We	ekly)								
Medical: United Healthcare	•										
HRA \$6K Plan  ☑ Employee Only \$59.91  HRA \$4K Plan	☐ Employee + Spouse	\$319.29	☐ Employee +	Child(ren)	\$264.10	0	+ Family	\$390.25			
Employee Only \$136.84	☐ Employee + Spouse	\$396.21	☐ Employee +	Child(ren)	\$341.02	2	+ Family	\$467.17			
HRA \$2K Plan  ☐ Employee Only \$213.76  ☐ I Decline Medical Coverage	☐ Employee + Spouse	\$473.13	☐ Employee +	Child(ren)	\$417.9	5	+ Family	\$544.09			
Limited Medical: ACI Benef	fits										
Minimum Essential Coverage Plan	1										
☐ Employee Only \$7.77 Indemnity Plan (Does not meet inc	☐ Employee + Spouse	\$17.55	☐ Employee +	Child(ren)	\$19.03	☐ Employee	+ Family	\$27.61			
☐ Employee Only \$19.61	☐ Employee + Spouse	\$37.24	☐ Employee +	Child(ren)	\$31.45	☐ Employee	+ Family	\$49.12			
Minimum Essential Coverage + Ir ☐ Employee Only \$27.37	Employee + Spouse	\$54.79	☐ Employee +	Child(ren)	\$50.48	☐ Employee	+ Family	\$76.74			
☐ I Decline Medical Coverage											
Dental: United Healthcare											
Dental PPO ☐ Employee Only \$13.45	☐ Employee + Spouse	\$27.44	☐ Employee +	Child(ren)	\$31.1	3	Family	\$45.63			
□ I Decline Dental Coverage											
Vision: United Healthcare											
☐ Employee Only \$3.04	☐ Employee + Spouse	\$5.59	☐ Employee + C	Child(ren)	\$5.86	6 ☐ Employee +	Family	\$8.78			
☑ I Decline Vision Coverage											

Provide the follo	nt Information owing information for each in		This Section Must Be Complete dual that should be insured for any of the above elections and list mailinge.	ed for All ng address fo	<b>Dependent</b> (or any dependent	Coverages that is different
Check Appropriate Box	Coverage Selection		Last Name, First, MI. Ø Only add mailing address if different from Employee Ø If spouse last name differs from the Employee, proof of marriage is required (i.e., marriage license)	Gender M F	Date of Birth	SSN (required)
☐ Enroll ☐ Cancel ☐ Change	☐ Medical ☐ Dental ☐ Vision	Spouse				
☐ Enroll ☐ Cancel ☐ Change	☐ Medical ☐ Dental ☐ Vision	Child				
☐ Enroll ☐ Cancel ☐ Change	☐ Medical ☐ Dental ☐ Vision	Child				
☐ Enroll ☐ Cancel ☐ Change	☐ Medical ☐ Dental ☐ Vision	Child				
Are they depended I affirm that all de	lent on you for support and r	mainter RS Sec	ction 152 definition of "dependent" so that premiums can be paid with pr	re-tax dollars	., if applicable: □	Yes 💢 No
redirection will aut I understand that:  I cannot examp of spot a chan defined I may be becom Prior to I hereb agreen I under If I do to election  For Coverages active work and/dependent(s) ma	intomatically be adjusted to reflection to thange or revoke any of my ples of possible qualifying everyouse, change in my spouse's engle in my spouse's employer-sed in the plan's Summary Plan be able to make a change to rine eligible for a premium assist to the first day of each plan years by authorize my employer to rement is signed.  In the signed in the plan's error of the exponent of the point of the exponent of the point of the terms of the policy.  If I have waived an dependents at a la insurance carrier of the continual of the exponent of the ex	ny elective my ele	tions or this compensation reduction agreement at any time during the plan ye clude: marriage, divorce, death of a spouse or child, birth or adoption of a child rment status from full-time to part-time or from part-time to full-time, a substan ored health coverage, etc.). Notification of change must be within 30 days of	rear unless I haild, termination ntial change in f the qualifying the Children's I days of this quaplan year. In the plan year ore the start of agly by my Emply I understand a that life insural date insurance rage for myseperson's insull receive a cell.	nave changes in fame or commencement of my family's health gevent. Qualifying Health Insurance Pualifying event.  For a following the date of each new plan year apployer.  For and agree that I must ance coverage for more would otherwise better and/or my eligurability, and the certificate of coverage for coverage for more would otherwise better and/or my eligurability, and the	mily status (some not of employment of employment of employment of events are employed are on which this ear, my current east satisfy all my eligible begin, in egible
X Enro	ollment Signature of Emplo	ovee			Date	