LAKECREST PARTNERS

Plan Year: January 1, 2025 – December 31, 2025

Effective Date: #1 Effect

Deadline to Submit: #2 Deadl

Property Name: #3 Property Name

Reason for Request *(check one of the following)*

☐ New Hire – Date of Hire: #5 New Hire Date of Hire ☐ Open Enrollment ☐ Qualifying Event – If so, state event & date: #8 Qualifyi

#6 Personal Information #4 Reason for Request check#7 Open Enrollment

Personal Information

Employee's Name (Last, First, MI)	Social Security #	Birth Date	Gender
	#9 Employees Name Last First MI	#10 Social Security	#11 Birth Date M ☐ F ☐ #12 Gender#13 Gender

Employee's Address	City	State	Zip
	#14 Employees Address	#15 City	#16 State #17 Zip

Phone Number	Email Address
	#18 Phone Number #19 Em

Coverage Elections *(deductions below are Bi-Weekly)*

Medical: United Healthcare

HRA $6K Plan

☐ #20 Employee Only $59.91 ☐ #21 Employee + Spouse $319.29 ☐ #22 Employee + Child(ren) $264.10 ☐ #39 Employee + Family $390.25

HRA $4K Plan

☐ #22 Employee Only $136.84 ☐ #23 Employee + Spouse $396.21 ☐ #23 Employee + Child(ren) $341.02 ☐ #40 Employee + Family_2 $467.17

HRA $2K Plan

☐ #24 Employee Only $213.76 ☐ #25 Employee + Spouse_2 $473.13 ☐ #24 Employee + Child(ren) $417.95 ☐ #41 Employee + Family_3 $544.09

☐ I Decline Medical Coverage #45 I Decline Medical Coverage

Limited Medical: ACI Benefits

Minimum Essential Coverage Plan

☐ #26 Employee Only_2 $7.77 ☐ #27 Employee + Spouse_3 $17.55 ☐ #25 Employee + Child(ren)_4 $19.03 ☐ #42 Employee + Family_4 $27.61

Indemnity Plan (Does not meet individual ACA mandate)

☐ #28 Employee Only_3 $19.61 ☐ #29 Employee + Spouse_4 $37.24 ☐ #26 Employee + Child(ren)_5 $31.45 ☐ #43 Employee + Family_5 $49.12

Minimum Essential Coverage + Indemnity

☐ #30 Employee Only_4 $27.37 ☐ #31 Employee + Spouse_5 $54.79 ☐ #27 Employee + Child(ren)_6 $50.48 ☐ #44 Employee + Family_6 $76.74

☐ I Decline Medical Coverage #45 I Decline Medical Coverage_2

Dental: United Healthcare

Dental PPO

☐ #47 Employee Only_5 $13.45 ☐ #48 Employee + Spouse_6 $27.44 ☐ #28 Employee + Child(ren)_7 $31.13 ☐ #45 Employee + Family_7 $45.63

☐ I Decline Dental Coverage #50 I Decline Dental Coverage

Vision: United Healthcare

☐ #51 Employee Only_6 $3.04 ☐ #52 Employee + Spouse_7 $5.59 ☐ #29 Employee + Child(ren)_8 $5.86 ☐ #54 Employee + Family_8 $8.78

☐ I Decline Vision Coverage #55 I Decline Vision Coverage

Enrollment forms MUST be received by applicable deadline.

Dependent Information

This Section Must Be Completed for All Dependent Coverages

Provide the following information for each individual that should be insured for any of the above elections and list mailing address for any dependent that is different from the employee's as noted on the previous page.

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	#60 Medical Dental Vision	#64 Last Name First MI Only a ☐ ☐ #65 undefined_2	#67 Date of Birth	#68 SSN re
☐ Enroll_2 ☐ Cancel_2 ☐ Change_2	☐ Medical_2 ☐ Dental_2 ☐ Vision_2	Child	#72 Medical Dental Vision_2	#78 Last Name First MI Only a ☐ ☐ #76 undefined_4	#79 Date of Birth	#80 SSN re
☐ Enroll_3 ☐ Cancel_3 ☐ Change_3	☐ Medical_3 ☐ Dental_3 ☐ Vision_3	Child	#87 ChildMedical Dental Vision	#88 Last Name First MI Only a ☐ ☐ #89 undefined_6	#91 Date of Birth	#92 SSN re
☐ Enroll_4 ☐ Cancel_4 ☐ Change_4	☐ Medical_4 ☐ Dental_4 ☐ Vision_4	Child	#99 ChildMedical Dental Vision_2	#100 Last Name First MI Only a ☐ ☐ #101 undefined_8	#103 Date of Birth	#104 SSN re

Have you included stepchildren as dependents? ☐ Yes ☐ No If "yes", indicate names: #108 If yes indicate nam

Are they dependent on you for support and maintenance? ☐ Yes ☐ No

I affirm that all dependents listed meet the IRS Section 152 definition of "dependent" so that premiums can be paid with pre-tax dollars, if applicable: ☐ Yes ☐ No

Premium Only IRS Code Section 125

I understand that if my required contribution to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have changes in family status (some examples of possible qualifying events include: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in my spouse's employment status from full-time to part-time or from part-time to full-time, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, etc.). Notification of change must be within 30 days of the qualifying event. Qualifying events are defined in the plan's Summary Plan Description.
- I may be able to make a change to my elections if I, or my dependents, lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP. Notification of change must be within 60 days of this qualifying event.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.
- I hereby authorize my employer to reduce my cash compensation by the amount(s) indicated for each pay period during the plan year following the date on which this agreement is signed.
- I understand that my election may impact my future Social Security benefits.
- If I do not file a new Agreement to Participate and a new Salary Reduction Agreement with the Plan Administrator before the start of each new plan year, my current elections will be continued (to the extent available) until I change my elections, and my salary will be reduced accordingly by my Employer.

For Coverages Offered UnitedHealthcare: I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependent(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

ENROLLMENT WAIVER: If I have waived any of the above insurance coverages, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and the insurance carrier reserves the right to reject my request.

Coverage summaries provided herein are intended as an outline of coverage only. Participants will receive a certificate of coverage. In the event of any discrepancy between this brochure and the certificate of coverage, the terms of the certificate of coverage will control.

X Enrollment Signature of Employee Date #112 Enrollment Signature of Spou #113 Dat

Enrollment forms MUST be received by applicable deadline.