



Submit Elections Confirmation

02:23 PM
12/03/2025
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New Hire for Samuel Adu Asare

Initiated On: 12/02/2025

Submit Elections By: 12/30/2025

Event Date: 12/01/2025

Total Employee Cost/Credit
\$11.04 Bi-weekly Cost

Elected Coverages

Benefit Plan	Coverage Begin Date	Deduction Begin Date	Coverage	Calculated Coverage	Dependents	Beneficiaries	Employee Cost (Bi-weekly)	Employer Contribution (Bi-weekly)
Dental - Anthem Dental Dental	01/01/2026	01/01/2026	Employee + Spouse		Mrs. Charlotte Tsawodzi		\$7.04	\$28.03
Vision - Anthem Vision Vision	01/01/2026	01/01/2026	Employee + Spouse		Mrs. Charlotte Tsawodzi		\$4.00	\$2.10
Short Term Disability (STD) - Prudential (Employee)	01/01/2026	01/01/2026	80% of Salary	\$8,666.66				\$39.23
Long Term Disability (LTD) - Prudential (Employee)	01/01/2026	01/01/2026	67% of Salary	\$7,258.33				\$31.00
Basic Life - PALIG (Pan-American Life Insurance Group) (Employee)	01/01/2026	01/01/2026	2 X Salary	\$260,000.00		Mrs. Charlotte Tsawodzi		\$16.07
Basic AD&D - PALIG (Pan-American Life Insurance Group) (Employee)	01/01/2026	01/01/2026	2 X Salary	\$100,000.00				\$1.05
Defined Contribution 401(k) - Principal Retirement	12/01/2025	12/01/2025						
Defined Contribution Roth - Principal Retirement	12/01/2025	12/01/2025						
EAP - Prudential	12/01/2025	12/01/2025						
Total:							\$11.04	\$117.48

Waived Coverages

Plan Type
Medical
Health Savings Account (HSA)
FSA - Health Care Spending Account
FSA - Dependent Care Spending Account
Voluntary Life
Voluntary Dependent Life
Optional AD&D

Beneficiary Designations

Benefit Plan	Requires Beneficiary	Beneficiary	Beneficiary - Primary Percentage / Contingent Percentage
Basic Life - PALIG (Pan-American Life Insurance Group) (Employee)	Yes	Mrs. Charlotte Tsawodzi	Primary Percentage 100

Electronic Signature

BENEFIT AND SALARY DEFERRAL ACKNOWLEDGEMENT 2026

IMPORTANT INFORMATION CONCERNING YOUR 2026 BENEFITS

YOUR BENEFIT ELECTIONS ARE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW AND THE 2026 ENCOVA INSURANCE BENEFIT PLAN DOCUMENTS.

THE TERMS AND CONDITIONS OF EACH OF ENCOVA INSURANCE'S 2026 BENEFIT PLANS ARE SET FORTH IN THE PLAN DOCUMENTS AND SUMMARY PLAN DESCRIPTIONS FOR EACH BENEFIT PLAN EXCEPT FOR THE HEALTH SAVINGS PLAN, WHICH IS NOT AN ERISA PLAN SPONSORED BY THE EMPLOYER

You completed your benefit elections for 2026 electronically through the Workday Human Resources Information System. During this process you authorized the payroll deductions associated with the benefits you elected.

In the event you elected coverage under the Anthem Blue Cross Blue Shield (Anthem) medical plans or you elected coverage under the Anthem dental and vision plan, you agree that the payroll deductions you authorized on the list of elected benefits will be made on a pre-tax basis in accordance with the terms of the Encova Insurance Premium Payment Plan and applicable tax rules. These elections may not be revoked during the 2026 plan year unless you experience a qualified change of status as defined in the plan documents for these plans.

Misstatements: I understand that misstatements, material misrepresentations or omissions may result in my coverage being void as of its effective date with no benefits payable. I understand it is unlawful for me or my dependents to knowingly provide false, incomplete or misleading facts to the healthcare providers for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of coverage, rescission of benefits, and legal damages.

Disclosure of Healthcare Information: I have selected the Anthem option for my medical, vision and dental coverage. I authorize any physician, dentist, other health professional, all hospitals and other health care institutions to provide Anthem and other benefit providers, contracted physicians and any independent claim administrators, consulting health professionals and utilization review organizations with whom Anthem and Encova has contracted, information concerning health care advice, treatment or supplies provided my dependents and/or myself (including those involving mental illness) relating to coverage under this plan. This information will be used for coordinating patient care, evaluating and administering claims for benefits, and for fulfilling obligations imposed on Anthem and others contracted for claims administration by federal or state law. Anthem may provide the employer named above with any benefit calculation used in the payment of these claims for the purpose of reviewing the experience and operation of the policy or contract. If you have any questions concerning the

benefits and services that are provided by or excluded under this agreement, please contact an Anthem or Express Scripts (pharmacy) member services representative before signing this form. My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

In the event you elected to contribute an amount to the Flexible Spending Account plan ("FSA"), you agree that:

- Your contributions to the FSA will be forfeited (if greater than \$680) if you do not use these contributions for qualifying expenses incurred in the 2026 plan year;
- Your contributions to the FSA will be made on a pre-tax basis by payroll deduction and may not be revoked during the 2026 plan year unless you experience a qualified change of status as defined in the plan documents for the FSA; and
- Your contributions to the FSA may only be used for qualifying expenses incurred during the 2026 plan year and incurred prior to the submission of a claim for reimbursement from the FSA.

In the event you elected to contribute an amount to your Health Savings Account ("HSA"), you agree that:

- Neither Encova Insurance's arrangement for making contributions to your HSA nor the HSA itself are welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).
- You have completed the Certification of Associate HSA Eligibility;
- You are solely responsible for ensuring that all contributions to your HSA do not exceed annual contribution limits;
- Your contributions to the HSA will be made on a pre-tax basis by payroll deduction.
- I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.
- I understand that I may not assign any payment under my Anthem program, unless allowable by law.
- I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 CFR. Parts 160 & 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

Duration of Authorization: This authorization shall remain valid for the term of this coverage or for so long as allowed by law.

CERTIFICATION OF ASSOCIATE HSA ELIGIBILITY

(If enrolled in a Qualified High Deductible Health Plan and Health Savings Account)

I understand that in order for Encova Insurance (the Employer) to contribute to a health savings account (HSA) on my behalf, I must meet all of the following HSA eligibility conditions:

1. I have ☐ self-only coverage OR ☐ family coverage under the Qualified High Deductible Health Plan, which I understand qualifies as a high-deductible health plan (QHDHP) under Code §223(c)(2).

2. I cannot be claimed as another person's tax dependent.
 3. I am not entitled to Medicare benefits.
 4. If I have any health coverage other than my coverage under the Health Plan, that coverage is either (a) QHDHP coverage (see paragraph A on page 2 of this form); or (b) permitted non-QHDHP insurance or coverage (see paragraph B on page 2 of this form). Examples of impermissible coverage that would make me ineligible include coverage under my spouse's or domestic partner's non-QHDHP health plan, general-purpose health flexible spending arrangement (health FSA), or general-purpose health reimbursement arrangement (HRA) that I have not elected to suspend.
- By acknowledging this form, I certify that all of the statements above are true. I agree that I will notify the Employer immediately in writing if I cease to meet any of these conditions. I also understand that the Employer will make contributions to an HSA on my behalf on the basis of my certification and that the Employer's HSA contributions and my own HSA contributions (if any) are subject to certain aggregate limits under federal tax law.

[Prudential Disability Coverage Disclosures](#)

Signed By Samuel Adu Asare
Date 12/03/2025