BENEFITS ELECTION FORM

FrankCrum®
PAYROLL • INSURANCE • BENEFITS • HR

1. YOUR PERSONAL INFORMATION

Name (Last, First, Middle Initial)		U.S. Social Security Number	
Street Address	City, State, Zip		Phone Number
Employer Name	Work Email	Email Address	

2. PERSONS TO BE ENROLLED/DEPENDENT INFORMATION

List all eligible persons to be covered using the first line for yourself. Select buttons under each benefit to enroll. Leave blank if opting out.

Name (Last, First, Middle Initial)	U.S. SSN	Relationship Type	DOB (MM/DD/YY)	Gender	Health	Dental	Vision	FSA	HSA	Hospital Indemnity	Critical Illness	Accident	Voluntary Life	LifeLock
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
					◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Total Enrolled														

3. HEALTH PLAN

Select one health plan, one coverage level, and one tax deduction preference to enroll:

- ◯ ______ ◯ ______
- ◯ ______ ◯ ______
- ◯ ______ ◯ ______
- ◯ ______ ◯ ______

- ◯ You Only
- ◯ You + Spouse
- ◯ You + Child
- ◯ You + Family
- ◯ Waive Coverage

- ◯ Pre-tax Deductions
- ◯ Post-tax Deductions

Aetna plans include $10,000 Basic Life Insurance.
Please see plan documents for plan and pricing information.

4. DENTAL PLAN

Select one dental plan, one coverage level, and one tax deduction preference to enroll:

- ◯ High PPO
- ◯ Mid PPO
- ◯ Low PPO
- ◯ DHMO - FL
- ◯ _____

- ◯ You Only
- ◯ You + Spouse
- ◯ You + Child
- ◯ You + Family
- ◯ Waive Coverage

- ◯ Pre-tax Deductions
- ◯ Post-tax Deductions

5. VISION PLAN

Select one vision plan, one coverage level, and one tax deduction preference to enroll:

- ◯ Vision High
- ◯ Vision Low

- ◯ You Only
- ◯ You + Spouse
- ◯ You + Child
- ◯ You + Family
- ◯ Waive Coverage

- ◯ Pre-tax Deductions
- ◯ Post-tax Deductions

6. METLAW*

- ◯ Enroll (covers spouse and dependents at additional premium)*
- ◯ Waive Coverage

*Post-tax Deductions

7. EMPLOYER-SPONSORED GROUP TERM LIFE INSURANCE PLAN*

- Employee Only
- Auto-enrolled where applicable

Flat Dollar _____

Multiples of Salary _____

*Post-tax Deductions

8. EMPLOYEE VOLUNTARY LIFE INSURANCE*

- **Employee:** $10,000 increments to the lesser of 5 times your basic annual earnings or $500,000; EOI lesser of 3 times pay and $100,000
- **Guarantee Issue:** Up to three times annual pay or $100,000, whichever is less for the employee.
- **Eligibility:** Available to employees working 30 hours or more per week

*Post-tax Deductions

Voluntary Term Life Rates:

Age*	Monthly Cost per $1,000 of Employee Coverage
<30	$0.11
30-34	$0.13
35-39	$0.14
40-44	$0.20
45-49	$0.25
50-54	$0.43
55-59	$0.80
60-64	$0.91
65-69	$1.52
70+	$4.16

- ◯ Employee Enroll
  Amount: $ _____
- ◯ Waive Coverage

9. SPOUSE VOLUNTARY LIFE INSURANCE*

Spouse/Domestic Partner:
$5,000 increments up to $100,000, with a maximum coverage amount of 50% of the employees VOL life plan coverage amount. Non-EOI guaranteed issue amount is $25,000.

*Post-tax Deductions

- ◯ Spouse Enroll
  Amount: $ _____
- ◯ Waive Coverage

10. CHILD VOLUNTARY LIFE INSURANCE*

Allowable Coverage Amounts:
$1,000/$2,000/$4,000/$5,000 & $10,000

*Post-tax Deductions

◯ Child Enroll

Amount: $

◯ Waive Coverage

11. FLEXIBLE SPENDING ACCOUNT (FSA)*

Employee Contribution Per Pay Period:

Annual Maximum Allowable Employee Contribution:

◯ Enroll

◯ Waive Coverage

*Pre-tax Deductions

12. LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT*

Employee Contribution Per Pay Period:

Annual Maximum Allowable Employee Contribution:

◯ Enroll

◯ Waive Coverage

*Pre-tax Deductions

13. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT*

Employee Contribution Per Pay Period:

◯ Enroll

◯ Waive Coverage

*Pre-tax Deductions

14. HEALTH SAVINGS ACCOUNT (HSA)*

Employee Contribution Per Pay Period:

Family Coverage Contribution Per Pay Period:

◯ Enroll

◯ Waive Coverage

*Pre-tax Deductions

15. COMMUTER BENEFITS*

Parking and/or Transit contribution limit:
$270/month per plan

Employee Contribution Per Pay Period:

◯ Enroll

◯ Waive Coverage

*Pre-tax Deductions up to contribution limit

16. HOSPITAL INDEMNITY*

Select coverage level to enroll:

Monthly Rates:
Employee Only $31.52
Employee + Spouse $60.08
Employee + Children $56.00
Family $95.20

◯ You Only

◯ You + Spouse

◯ You + Child

◯ You + Family

◯ Waive Coverage

*Post-tax Deductions

17. ACCIDENT*

Select one plan and one coverage level to enroll:

Low Plan Monthly Rates:
Employee Only $5.68
Employee + Spouse $10.66
Employee + Children $11.59
Family $14.62

◯ Low Plan

High Plan Monthly Rates:
Employee Only $10.77
Employee + Spouse $19.96
Employee + Children $21.68
Family $27.40

◯ High Plan

◯ You Only
◯ You + Spouse
◯ You + Child
◯ You + Family
◯ Waive Coverage

*Post-tax Deductions

18. CRITICAL ILLNESS*

Select one plan and one coverage level to enroll:

Based on age of employee.

◯ You Only
◯ You + Spouse
◯ You + Child
◯ You + Family
◯ Waive Coverage

*Post-tax Deductions

$15,000 BENEFIT MONTHLY RATES:

Age*	Employee Only	Employee + Spouse	Employee + Children	Family
<25	$3.60	$6.15	$6.45	$9.00
25-29	$3.90	$6.45	$6.75	$9.45
30-34	$5.55	$8.85	$8.40	$11.70
35-39	$7.95	$12.45	$10.95	$15.30
40-44	$12.30	$18.75	$15.30	$21.60
45-49	$18.90	$28.05	$21.75	$30.90
50-54	$28.35	$41.25	$31.20	$44.25
55-59	$40.65	$58.65	$43.50	$61.50
60-64	$59.25	$84.60	$62.10	$87.60
65-69	$89.70	$127.20	$92.55	$130.05
70+	$135.00	$192.45	$137.85	$195.45

◯ $15K Benefit Plan

$30,000 BENEFIT MONTHLY RATES:

Age*	Employee Only	Employee + Spouse	Employee + Children	Family
<25	$7.20	$12.30	$12.90	$18.00
25-29	$7.80	$12.90	$13.50	$18.90
30-34	$11.10	$17.70	$16.80	$23.40
35-39	$15.90	$24.90	$21.90	$30.60
40-44	$24.60	$37.50	$30.60	$43.20
45-49	$37.80	$56.10	$43.50	$61.80
50-54	$56.70	$82.50	$62.40	$88.50
55-59	$81.30	$117.30	$87.00	$123.00
60-64	$118.50	$169.20	$124.20	$175.20
65-69	$179.40	$254.40	$185.10	$260.10
70+	$270.00	$384.90	$275.70	$390.90

◯ $30K Benefit Plan

19. EMPLOYER-SPONSORED DISABILITY

Auto-enrolled where applicable.

Short Term Disability

- Weekly Benefit Amount: 60%
- Maximum Weekly Benefit: $1,730
- Minimum Weekly Benefit: $20
- Elimination Period: 14 days
- Duration:

Long-Term Disability

- Monthly Benefit: 60% of pre-disability earnings
- Maximum Monthly Benefit: $7,500
- Maximum Salary: $150,000
- Minimum Monthly Benefit: $100
- Elimination Period: 90 or 180 days or until the end of the STD
- Duration:

20. VOLUNTARY SHORT TERM DISABILITY*

- **Elimination Period:** 14 days for injury or sickness including pregnancy
- **Benefit:** 60% of weekly earnings up to a weekly benefit maximum of $2,308.00
- **Note:** Option 1 STD coincides with Option 1 LTD. Option 2 STD coincides with Option 2 LTD.

Disability Age
Per $10 Weekly Benefit

Age	13 Week Benefit Duration	26 Week Benefit Duration
>25	$0.30	$0.43
25-29	$0.32	$0.45
30-34	$0.32	$0.46
35-39	$0.29	$0.42
40-44	$0.32	$0.56
45-49	$0.38	$0.54
50-54	$0.47	$0.69
55-59	$0.59	$0.85
60-64	$0.69	$1.00
+65	$0.83	$1.20

◯ 13 Week Duration (Option 1)

◯ 26 Week Duration (Option 2)

◯ Waive Coverage

*Post-tax Deductions

21. VOLUNTARY LONG TERM DISABILITY*

- **Elimination Period:** Option 1 90 Days or Option 2 180 days
- **Benefit:** 60% of monthly earnings up to a monthly benefit maximum of $10,000

Benefit Duration

Age on Date of Disability	Benefit Duration
< 60	To age 65
60-64	5 Years (60 Months)
65-69	To age 70
70+	12 Months

Disability Age
Per $100 Covered Monthly Payroll

Age	90 Day Elimination Period	180 Day Elimination Period
<35	$0.20	$0.11
35-39	$0.41	$0.33
40-44	$0.47	$0.46
45-49	$0.77	$0.63
50-54	$1.03	$0.83
55-59	$1.17	$0.97
60-64	$0.92	$0.72
65+	$0.35	$0.26

◯ 90 Day Elimination Period (Option 1)

◯ 180 Day Elimination Period (Option 2)

◯ Waive Coverage

*Post-tax Deductions

22. PET ASSURE VETERINARY DISCOUNT PLAN*

Select Vet Plan to enroll:

- ◯ Vet Discount Plan ($8/Month for unlimited number of pets)
- ◯ Waive Coverage

Select Prescription Plan to enroll:

- ◯ One Pet ($4.50/Month)
- ◯ Unlimited Number of Pets ($8.50/Month)
- ◯ Waive Coverage

*Post-tax Deductions

23. LIFELOCK*

Select one plan and one coverage level to enroll:

LifeLock with Norton - Monthly Rates

Coverage	Benefit Essential	Benefit Premier
Employee	$8.50	$21.25
Employee + Dependent(s)	$17.00	$42.50

- ◯ LifeLock Benefit Plan
- ◯ LifeLock Ultimate Benefit Plan

- ◯ You Only
- ◯ You + Spouse
- ◯ You + Child
- ◯ You + Family
- ◯ Waive Coverage

*Post-tax Deductions

TERMS & CONDITIONS

Other Coverage Certification

I am waiving the FrankCrum health plan coverage because I have coverage elsewhere. I certify that I have other health plan coverage as indicated below.

Check one box and provide the required information.

◯ Outside of FrankCrum as a dependent on another person's employer group health plan.

Employee Name

Employer Name

◯ Through a governmental-sponsored health plan or private insurance policy.

Plan Name

I understand that if I do not gain special enrollment rights upon a loss of other coverage, my next opportunity to enroll in a FrankCrum health plan will be the next annual open enrollment period with coverage effective November 1, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption. I understand that I am also waiving prescription drug coverage.

Dependents

Any dependents I am enrolling meet the eligibility requirements described in the benefit enrollment materials. Upon request, I will furnish a copy of an affidavit of eligibility, my marriage license, divorce decree, the section of my IRS Form 1040 listing dependents, court orders establishing guardianship or adoption, and/or the birth certificate of any individual for whom I seek benefits. By my signature on this enrollment form, I certify that I understand and agree that to claim coverage for an ineligible dependent is serious misconduct, and in the event of such conduct, I agree to reimburse FrankCrum for any cost incurred, and may be subject to disciplinary action. If there is any change in the status of any of the individuals listed on this form, I will be responsible for notifying FrankCrum within 30 days of such change.

Deduction Authorization

I have reviewed the benefit enrollment materials and agree to the terms and conditions listed there. I authorize deductions, if appropriate, for my benefit choices based on the current rate and any future rate changes (increases or decreases).

Affirmation & Understanding

I affirm under penalty of perjury that the preceding statements are true and complete to the best of my knowledge. I further understand that any misrepresentation of these statements may result in serious consequences including loss of benefits, discipline, or appropriate legal action.

Limitations

FrankCrum, in its sole discretion, may modify, amend, or terminate the benefits provided with respect to any individual receiving benefits, including active employees, retirees, and their dependents. Although FrankCrum has elected to provide these benefits this year, no individual has a vested right to any of the benefits provided. Nothing in these materials gives any individual the right to continued benefits beyond the time FrankCrum modifies, amends, or terminates the benefit. Anyone seeking or accepting any of the benefits provided will be deemed to have accepted the terms of the benefits programs and FrankCrum's right to modify, amend, or terminate them.

Printed Name _____ Date _____

Signature _____