2020 SALARIED AND CLERICAL/TECHNICAL ASSOCIATES BENEFITS ENROLLMENT/CHANGE FORM

Employee Information

Name:____ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Street: ____ City: ______________ State: _____ Zip:________

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Date of Birth: _______________ Date of Hire: _______________ Check one: ☐ Hourly ☐ Salary

Medical Premium Incentive

A premium incentive towards the cost of your medical insurance is offered for those Salaried and Clerical Technical associates who reach Silver status or above through the Vitality Program.

2020 Associate Contribution Rates

Tier Level	Basic Plan (per pay)				Plus Plan (per pay)			
	Bronze	Silver	Gold	Platinum	Bronze	Silver	Gold	Platinum
Employee Only	$18.00	$8.00	No Cost	No Cost	$58.00	$48.00	$31.00	$23.00
Employee + Child(ren)	$55.00	$45.00	$28.00	$21.00	$158.00	$153.00	$109.00	$87.00
Employee + Spouse	$58.00	$48.00	$30.00	$22.00	$185.00	$175.00	$116.00	$93.00
Family	$74.00	$63.00	$38.00	$26.00	$220.00	$210.00	$140.00	$105.00

Medical Plan Option (check one): ☐ Basic Plan ☐ Plus Plan

Tier Level (check one):

Employee Only	Employee + Child/Children	Employee + Spouse	Employee + Family	No Coverage
☐	☐	☐	☐	☐

Do you, your spouse, or children have other medical insurance coverage? Yes ☐ No ☐ If YES, please provide names of those covered, the carrier name, and policy number:____

Dental Plan	Per Pay
Employee Only	$5.25
Employee + Spouse	$10.00
Employee + Child	$10.00
Family	$19.25

Dental (check one):

Employee Only	Employee + Child	Employee + Spouse	Employee + Family	No Coverage
☐	☐	☐	☐	☐

Vision Plan	Per Pay
Employee Only	$2.04
Employee + Spouse	$3.98
Employee + 2 or more	$3.98
Employee + Child	$5.84

Vision (check one):

Employee Only	Employee + Child	Employee + Spouse	Employee + Family	No Coverage
☐	☐	☐	☐	☐

Health Savings Account (HSA) Election

Please indicate the amount you wish to contribute to your 2020 Health Savings Account via payroll deduction or write $0 for no contribution. The maximum annual HSA contribution amount for 2020 is $3,550 for employee-only and $7,100 for family coverage (including any employer contribution amount). An additional $1,000 catch-up contribution is allowed for participants age 55 and older.

HSA Election $____________________ (per pay)

Dependent Care Flexible Spending Account

Please indicate the amount you wish to contribute to your 2020 Dependent Care Flexible Spending Account or write $0 for no contribution. The maximum annual Dependent Care FSA contribution amount for 2020 is $5,000.

Dependent Care FSA Election $____________________ (per pay)

Dependent Information

Please complete the section below for any eligible dependent you wish to enroll or remove from coverage. Eligible dependents include your legal spouse and your child(ren) up to age 26. Disabled dependent children of any age are eligible for coverage as long as they are enrolled at the time their coverage would otherwise have ended. Certification of disability for coverage beyond age 26 may be required.

Name (First & Last)	DOB (M/D/Y)	SS#	Gender (M/F)	Relationship	PLEASE CHECK APPLICABLE:					
					MEDICAL		DENTAL		VISION	
					☐ ADD	☐ REMOVE	☐ ADD	☐ REMOVE	☐ ADD	☐ REMOVE
					☐ ADD	☐ REMOVE	☐ ADD	☐ REMOVE	☐ ADD	☐ REMOVE
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					☐ ADD	☐ REMOVE	☐ ADD	☐ REMOVE	☐ ADD	☐ REMOVE

Confirmation

I have read and understand the healthcare benefit choices available to me. I acknowledge the elections I have made for myself and my eligible dependents and authorize Metromont to withhold any contributions for medical, dental, vision, Health Savings Account, and/or Dependent Care Flexible Spending Account on a pre-tax basis. I further understand that the coverage I have elected will stay in effect until the next open enrollment period, and that I cannot change my coverage elections unless I have a qualified status change as defined by the Program.

I understand that if I elect Metromont's medial insurance, my spouse (if applicable) and I will be enrolled in Metromont's Vitality Wellness Program. I understand that my status level in Vitality can be achieved through several participatory options including but not limited to online education, physical activity (or reasonable alternatives if unable to complete physical activity), purchasing healthy food items, Vitality squares, checking in on goals, etc. If I choose to complete a Vitality Check, it will be on a voluntary basis to achieve the points associated with completing the Check.

I hereby authorize any physician, medical practitioners, hospital, clinic, institution, or other medical or medical-related facility, insurance company, the Medical Information Bureau, or other organization or persons that has any records of myself, my medical history, or my dependents to give the Claims Administrator, their representatives, or reinsurer any information needed to complete enrollment, claim adjudication and payment.

____ Associate Signature

____ Date

For HR Use Only

Effective Date: ________________________________ Location: ____

Completed By: ________________________________