CYPRESS BENEFITS GROUP

EMPLOYEE ELECTION FORM

DAY & ROSS

EMPLOYEE **MUST** TURN ENROLLMENT FORMS IN TO AN H.R. REPRESENTATIVE **PRIOR TO** THE EFFECTIVE DATE OF COVERAGE

Failure to properly submit forms will constitute a waiver

☐ NEW SUBSCRIBER ☐ **WAIVER** *(Signature Required)* ☐ COBRA

Day & Ross, USA New Hire Election Form

1 EMPLOYEE

Last Name	First Name	M.I.	Title *(Jr., Sr., etc.)*

Street Address	Apt #

City	State	Zip Code	Hours Worked Per Week

Social Security #	Date of Birth (MM-DD-YY)	Gender M F	Marital Status (S)ingle (M)arried	☐ DRIVER	☐ OFFICE
		☐ ☐	☐ ☐		

Home Phone #	**Hire Date:**	**Effective Date:**

2 DEPENDENTS

Name (Last, First, M.I.)	Relationship	Social Security #	Birth Date	Gender	Disabled (Y/N)
	Subscriber				

2A PROOF OF DEPENDENCY

☐ **Birth Certificate** ☐ **Marriage Certificate** ☐ **Drivers License** ☐ **Tax Return**

3 PLANS

MEDICAL PLAN CareFirst Administrators	**DENTAL PLAN** MetLife	**VISION PLAN** Superior Vision	**Basic Life/STD** AUL (100% Employer Paid)	**Voluntary LTD** One America/AUL
☐ **Silver** ☐ **Gold**	☐ **Core** ☐ **Enhanced**	☐ Employee	☑ Life/AD&D	☑ **Core Benefit Period**
	Please select Coverage:	☐ Employee & 1	☑ STD	☐ Enhanced Period
☐ Employee	☐ Employee	☐ Employee + 2 or more		☐ Decline LTD
☐ Employee & Child(ren)	☐ Employee & Child(ren)	***Specify if adding dependent coverage**		
☐ Employee & Spouse	☐ Employee & Spouse			**You are automatically enrolled in the core plan unless you elect otherwise**
☐ Family	☐ Family			
☐ Waive		☐ Waive		

4 *VOLUNTARY LIFE PLANS - OneAmerica/AUL

Employee Life Insurance: ☐

Amount $ _____

($10,000 to $300,000)

Decline: ☐

Guaranteed Issue: $100,000

Spouse Life Insurance: ☐

Amount: _____

($5,000 to $150,000)

Decline: ☐

Spouse Name: _____

Guaranteed Issue: $30,000

Children Life Insurance:

Amount: ☐ $2,500 ☐ $5,000 ☐ $10,000

Decline: ☐

Spouse Date of Birth: _____

***Payroll deductions for Voluntary benefits may increase due to an age bracket change or salary increase**
****Child coverage limited to age 26**

5

Employee Occupation: _____ Employee # _____ Employee Salary: _____ Salary Mode: _____

Primary Beneficiary: _____ Relationship: _____

Secondary Beneficiary: _____ Relationship: _____

6

EMPLOYEE SIGNATURE: _____ DATE: / /

EMPLOYER SIGNATURE VERIFICATION: _____ DATE: / /

For Internal Use Only:

____ Health ____ Dental ____ Vision ____ AUL ____ COBRA ____ Spread

Day & Ross, USA Payroll Deduction Form

SECTION 125 ELECTION FORM
Effective 6/1/2020

NAME: _____ **DATE OF BIRTH:**_____

SOCIAL SECURITY #:_____ **TERMINAL:**_____

HEALTH- CAREFIRST BC/BS

SILVER

ALL EMPLOYEES

_____ INDIVIDUAL	$20.82/WEEK
_____ EMPLOYEE/CHILD(REN)	$38.86/WEEK
_____ EMPLOYEE/SPOUSE	$56.10/WEEK
_____ FAMILY	$61.09/WEEK

GOLD

ALL EMPLOYEES

_____ INDIVIDUAL	$26.02/WEEK
_____ EMPLOYEE/CHILD(REN)	$48.58/WEEK
_____ EMPLOYEE/SPOUSE	$70.13/WEEK
_____ FAMILY	$76.36/WEEK

WAIVE HEALTH COVERAGE _____ **I HAVE OTHER HEALTH COVERAGE** ____YES ____NO

DENTAL- METLIFE

CORE PLAN - OPTION 1

_____ INDIVIDUAL	$0.00/WEEK
_____ EMPLOYEE/CHILD(REN)	$3.49/WEEK
_____ EMPLOYEE & SPOUSE	$3.63/WEEK
_____ FAMILY	$7.47/WEEK

ENHANCED PLAN- OPTION 2

_____ INDIVIDUAL	$0.97/WEEK
_____ EMPLOYEE/CHILD(REN)	$10.26/WEEK
_____ EMPLOYEE & SPOUSE	$10.06/WEEK
_____ FAMILY	$16.32/WEEK
_____ WAIVE	

I HAVE OTHER DENTAL COVERAGE ____YES ____NO
****PLEASE NOTE YOU MAY ONLY WAIVE WITH PROOF OF OTHER COVERAGE**

VISION- SUPERIOR VISION

_____ INDIVIDUAL	$0.87WEEK
_____ EMPLOYEE + ONE	$1.64/WEEK
_____ EMPLOYEE + TWO OR MORE	$2.21/WEEK
_____ WAIVE	

I HAVE OTHER VISION COVERAGE ____YES ____NO
****PLEASE NOTE YOU MAY ONLY WAIVE WITH PROOF OF OTHER COVERAGE**

This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new elections are on account of and consistent with a change in family status (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child and termination of employment of a spouse). Participation in this plan with automatically cease with the termination of the employee's employment.

I understand that the selection of the insurance benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this program, that the premium for the contract selected may be adjusted by the insurance company issuing the contract and, in most instances, an application for insurance must also be completed. I also understand that should the premiums for the contract selected be the adjusted by the company, my income will be reduced or increase as necessary to pay for the premium under the terms of the Section 125 Flexible Benefit Plan.

I understand the coverage of which I am applying will take effect on _____provided the policy has been issued as applied for. Benefits will not be payable prior to this date.

Deductions unless otherwise noted will be deducted on a pre-tax basis.

If you wish to have deductions taken post-tax please check: _____Post-tax _____Pre-tax

Signature: **Date:**

_____ _____