Employee Election Form

March 1, 2025 - February 28, 2026

Benefits, inc.

Hire Date

Employee Name:

Dental		Principal
Network	Principal Dental PPO	
Preventive Services	Covered @ 100%	**Deductible**
Basic Services	Covered @ 80% after Deductible	$50 (maximum 3 per Family)
Major Services	Covered @ 50% after Deductible	**Annual Maximum**
Orthodontics	Not Covered	$1500 per Covered Person - Annual Rollover benefit $375
Cost per Pay Period (52)		
Employee Only	☐	$0.00
Employee/Spouse	☐	$5.11
Employee/Child(ren)	☐	$8.01
Family	☐	$14.08
☐ DECLINE DENTAL COVERAGE		

Vision		Principal
Network	VSP	**Frequency**
Eye Examination	$10 Copay	All vision benefits are available once every 12 months except the Fames Benefit. It is payable once every 24 months in lieu of contacts.
Lenses	$25 Copay	
Frames	$150 Allowance	
Contacts (in lieu of glasses)	$150 Allowance	
Cost per Pay Period (52)		
Employee Only	☐	$0.00
Employee/Spouse	☐	$1.02
Employee/Child(ren)	☐	$1.27
Family	☐	$2.54
☐ DECLINE VISION COVERAGE		

Accident		Principal
Pays a cash benefit for sustained injuries on and off the job		
Benefit varies based on the type and severity. Please refer to the benefits payable for the full summary.		
Wellness screening	$50	
Cost per Pay Period (52)		
Employee Only	☐	$2.65
Employee/Spouse	☐	$4.05
Employee/Child(ren)	☐	$4.52
Family	☐	$6.94
☐ DECLINE ACCIDENT COVERAGE		

This is a Benefit Overview - For full plan information please refer to the applicable Benefit Summary

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Enrollment Information

Employee Last Name	First Name	SSN	Date of Birth	Gender
				☐ M ☐ F

Address	City, State	Zip Code

Email	Phone

Dependent Information

Spouse Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 1 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 2 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 3 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 4 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Section 125 Agreement

I cannot change or revoke this Benefit Election Agreement before the beginning of the next Plan Year unless a change in status occurs. For this purpose, a change in status includes:

MARRIAGE / DIVORCE

ADDITION / LOSS OF A DEPENDENT

TERMINATION / COMMENCEMENT OF EMPLOYMENT

TAKING AN UNPAID LEAVE OF ABSENCE

Further, I understand that any requested change must be on account of and consistent with the change in status and that the change must be requested within 30 days of the recognized event.

My execution of this Benefit Election Agreement does not begin coverage under any benefit or insurance policy. The terms and conditions of the underlying benefit plan or insurance policy with determine my entitlement to benefits thereunder.

Prior to the beginning of each plan year, I may be offered the opportunity to change my benefit election(s) for the following plan year. If I fail to submit a Benefit Election Agreement at that time, I will continue any coverages for the new plan year, and I will continue to have the appropriate amounts withheld from my salary for my coverage.

The Company and I hereby agree that my cash compensation will be reduced by the amounts set forth for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement.)

Employee Signature **Date**