BENEFIT ELECTION & WAIVER FORM | HOPE

Please complete the following election form for your 2025 benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Hope and are therefore waiving all coverage, please check the box for waiving all coverage. If waiving all coverage, complete only the top section of the form and sign/date at the bottom of the back page. You must provide a reason for waiving coverage.

☐ **Open Enrollment** ☐ **New Hire** ☐ **Change of Status*** ☐ **Waiving all Coverage****

***Qualifying Event:** _____ ****Reason for Waiving:** _____

**Change of Status is only applicable if you have experience a qualifying life event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*

***Please note that all employees will be enrolled in employer sponsored Basic Life & AD&D, as well as employee contributed STD and LTD .*

Company Name: _____ Social Security #: _____

Employee Name: _____ Date of Hire: _____

Address: _____ Coverage Effective: _____

City, State, Zip: _____ Telephone #: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

MEDICAL COVERAGE ELECTION

☐ **Pre-tax basis** ☐ **Post-tax basis** ☐ **Please check if waiving Medical**

Check Box if Electing (per pay deduction)	POS (w/ Wellness)	POS (w/o Wellness)	HDHP (w/ Wellness)	HDHP (w/o Wellness)
Employee Only	$133.56 ☐	$146.92 ☐	$75.26 ☐	$82.79 ☐
Employee + Spouse	$318.00 ☐	$349.80 ☐	$175.96 ☐	$193.56 ☐
Employee + Child(ren)	$342.38 ☐	$376.62 ☐	$180.20 ☐	$198.22 ☐
Family	$402.79 ☐	$443.07 ☐	$222.90 ☐	$245.19 ☐

Note: Fill out dependent information below if you elect a tier other than Employee Only.

To participate in the Wellness Program, you will need to have your preventive annual exam and have the Wellness Affidavit completed by your provider and turned into Human Resources.

DENTAL COVERAGE ELECTION

☐ **Pre-tax basis** ☐ **Post-tax basis** ☐ **Please check if waiving Dental**

Check Box if Electing	Per 26 Pay Periods
Employee Only	$12.77 ☐
Employee + Spouse	$24.71 ☐
Employee + Child(ren)	$34.98 ☐
Family	$49.57 ☐

Note: Fill out dependent information below if you elect a tier other than Employee Only.

VISION COVERAGE ELECTION

☐ **Pre-tax basis** ☐ **Post-tax basis** ☐ **Please check if waiving Vision**

Check Box if Electing	Per 26 Pay Periods
Employee Only	$2.49 ☐
Employee + Spouse	$4.72 ☐
Employee + Child(ren)	$4.96 ☐
Family	$7.29 ☐

Note: Fill out dependent information below if you elect a tier other than Employee Only.

DEPENDENT INFORMATION

First and Last Name	Social Security #	Birth Date	Gender	Relationship	Check Applicable Box(es) Medical	Dental	Vision

BPA TROXELL BENEFITS

BASIC LIFE/AD&D

*Benefit provided by Hope at no cost to employees

	Exempt Employees	Non-Exempt Employees
Benefit Amount	3x Annual Salary (Max $100k)	3x Annual Salary (Max $50k)
Reduction Schedule	Reduce 35% at age 70, 50% at age 75	Reduce 35% at age 70, 50% at age 75
Accelerated Death Benefit	Up to 50% of benefit (24 months or less life expectancy)	Up to 50% of benefit (24 months or less life expectancy)
Beneficiary Resource Services	Included	Included
Travel Resource Services	Included	Included

BASIC LIFE/AD&D BENEFICIARIES

Primary Beneficiary Full Name	Address	Date of Birth	SSN	Relationship	Benefit%
					%
					%
					%
				Total (must equal 100%)	%

Contingent Beneficiary Full Name	Address	Date of Birth	SSN	Relationship	Benefit%
					%
					%
					%
				Total (must equal 100%)	%

SHORT AND LONG-TERM DISABILITY (employee is responsible for the full cost of premium)

- ☐ I make $49,999 or less annually : Cost is $16.50 per 26 pay periods
- ☐ I make between $50,000—$69,999 annually : Cost is $29.00 per 26 pay periods
- ☐ I make between $70,000—$89,999 annually : Cost is $38.00 per 26 pay periods
- ☐ I make $90,000 — $109,999 annually : Cost is $45.00 per 26 pay periods
- ☐ I make $110,000 or more annually : Cost is $65.00 per 26 pay periods

AUTHORIZATION AND SIGNATURE

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes will be during open enrollment period for a 1/1/2025 effective date, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact Human Resources within 30 days of the life status change.

My signature below authorizes Hope to deduct insurance premiums based on my pre or post tax elections:

Name: _____ **Signature:** _____ **Date:** _____

Questions? Contact your Hope HR representative		
Orietta Moore	omoore@hope.us	217-461-4362 Ext. 30453

BPA TROXELL BENEFITS