Synter Resource Group

2015-2016 BENEFITS ELECTION FORM

- ❑ New Enrollment
- ❑ Address Change
- ❑ Add Spouse/Dependent (check new coverage level below)
- ❑ Remove Spouse/Dependent (check new coverage level below)
- ❑ Drop Coverage
- ❑ Other: _____

Effective Date: _____

Earnings: _____ per _____

Hours Worked per Week: _____

HR Use Only

Employee Name: _____ **Date of Hire:** _____

❑ Male ❑ Female **Date of Birth** _____ **SSN** _____

Address: _____

City:_____**State:**_____ **Zip:**_____

Spouse Full Name, if to be covered:

_____ ❑ Male ❑ Female Date of Birth _____ SSN _____

Child(ren) Full Names, if to be covered:

_____ ❑ Male ❑ Female Date of Birth _____ SSN _____

_____ ❑ Male ❑ Female Date of Birth _____ SSN _____

_____ ❑ Male ❑ Female Date of Birth _____ SSN _____

_____ ❑ Male ❑ Female Date of Birth _____ SSN _____

Medical – BCBS of SC

Core Plan (HDHP/HSA)

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

Buy-up Plan (Copays)

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

☐ Decline

Dental – Delta Dental

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

☐ Decline

Vision – PEP

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

☐ Decline

Basic Life/AD&D – Lincoln

✓ Amount: $25,000

Voluntary Life/AD&D – Lincoln

(Complete EOI Form)

Employee

- ☐ Elect – Amount*: _____
- ☐ Decline

Spouse

- ☐ Elect – Amount*: _____
- ☐ Decline

Child

- ☐ Elect – Amount*: _____
- ☐ Decline

Long Term Disability- Lincoln

✓ Employer Paid

Short Term Disability- Lincoln

- ☐ Elect (Complete EOI Form)
- ☐ Decline

Keep your Life/AD&D Insurance Beneficiary Designation up-to-date for your with Human Resources – complete the Beneficiary Form along with this enrollment form

I understand that if I decline the coverage offered to me/my dependents during this Open Enrollment Period or as a New Hire, I/my dependents will be subject to the IRS "qualifying event" rules under Federal Law should I decide to enroll after this eligibility date. I further understand that without a "qualifying event" I will have to wait until the next Open Enrollment Period to make any changes to my elections.

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

Section 125 Salary Reduction Agreement

Enrollment Form

Pre-Tax Salary Reduction: (Employee contributions to the Employer-Sponsored Benefit Plans)

AMOUNTS ARE PER PAY PERIOD

Payroll Frequency: Semi-Monthly (24)

Medical Insurance: $_____ Dental Insurance: $_____ Vision Insurance: $_____

Date of First Payroll Deduction:_____

❑ I waive my right to have my benefit premiums deducted from my paycheck pre-tax, at this time.

Health Savings Account:

❑ HSA Account: Annual Election: $_____ Per Pay Check Deduction:$_____

Date of First Payroll Deduction:_____

❑ I waive my right to contribute to a Health Savings Account, at this time.

Flexible Spending Accounts:

❑ FSA Medical Account: Annual Election: $_____ Per Pay Check Deduction:$_____

❑ FSA Dependent Care: Annual Election: $_____ Per Pay Check Deduction:$_____

Date of First Payroll Deduction:_____

❑ I waive my right to participate in the Flexible Spending Accounts, at this time.

Section 125 Salary Reduction Agreement

I understand that I am allowed to reduce my salary for the purchase of qualified benefits as part of a flexible benefits plan ("plan") under Section 125 of the Internal Revenue Code. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for this coverage. I further authorize future adjustment in the amount of the salary reduction in the event that the cost of coverage in any program selected for "Pre-Tax" is changed during the plan year. I further authorize a payroll deduction for the amount necessary payroll deduction for the amount necessary to pay for the coverage selected for "Post-Tax", if any.

Employee Signature**:**_____ Date**:** _____

Print Name**:**_____