2021 Benefits Election Form

Clock #:	____________
Date of Hire:	____________
Effective Date:	____________
Entered on Flex Facts:	____________

Plan Holder Name (Company Name) - The Shadowfax Corporation	Location Name

Section I - Basic Employee and Dependent Information – *This portion is to be completed in full by the Employee*

Employee's Name (Last, First, MI)	Social Security No.	Birth Date	Gender M F
Employee's Street Address	City/State/Zip	Phone	
Marital Status: ☐ Single ☐ Married	Dependent Children? ☐ Yes ☐ No		

Dependent Information (below) must be **completed in full** if you intend to cover your dependents under the medical, dental, and/or vision insurance. You must indicate if you are adding a new dependent to coverage, deleting a dependent from coverage or changing dependent information (1st column). You must also indicate the plan that you intend to enroll your dependent in (last column).

A = Add D = Delete C = Change NC = No Change	DEPENDENT NAME (Last, First, Middle Initial)	GENDER	RELATIONSHIP	BIRTH DATE	SSN	STUDENT	M = Medical/Rx D = Dental V = Vision
		M F				Y N	M D V
		M F				Y N	M D V
		M F				Y N	M D V
		M F				Y N	M D V
		M F				Y N	M D V

Section II - Health Care Benefit Plan Enrollment - *This portion is to be completed in full by the Employee*
Please check the benefit plan and coverage status of the plan that you are enrolling in.

Medical Insurance	**Prices below are per pay period** **If you completed the Wellness Initiatives within the required time period, your medical insurance contribution reduced by $40.00 per pay **		
Benefit Plan (check one)	**Coverage Status (check one)**		
	Single	**Parent and Child**	**Parent and Children**
☐ Highmark – PPO CB 500	☐ $85.00	☐ $408.90	☐ $839.24
☐ Waive Coverage			

Dental Insurance	**Prices below are per pay period**				
Benefit Plan (check one)	**Coverage Status (check one)**				
	Single	**EE + Spouse**	**Parent and Child**	**Parent and Children**	**Family**
☐ Delta Dental	☐ $0.00	☐ $21.32	☐ $21.32	☐ $21.32	☐ $21.32
☐ Waive Coverage					

Vision Insurance	**Prices below are per pay period**				
Benefit Plan	**Coverage Status (check one)**				
	Single	**EE + Spouse**	**Parent and Child**	**Parent and Children**	**Family**
☐ Vision Benefits of America	☐ $0.00	☐ $3.32	☐ $3.32	☐ $3.32	☐ $3.32
☐ Waive Coverage					

Section III – Authorization
I am enrolling for coverage and I authorize my employer to deduct from my earnings on a pretax basis until further notice my contributions for insurance. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. I also understand that if I waived participation in one or more of these plans that I will not be eligible to enroll in them until the next Open Enrollment unless I have a change in status and the requested benefit change is due to and consistent with the change in status. I further understand that these benefits will remain in effect and cannot be changed or revoked unless the change is due to and consistent with a change in status or I make a change in a future open enrollment period. I understand that the insurance is not in force until approved by the insurance carrier(s).

Employee Signature:______________________________ **Date:**______________