# 2018 Benefits Open Enrollment

It's time for our annual benefits open enrollment. Any changes you make will be effective January 1, 2018 and will continue through December 31, 2018. Refer to the benefits rates for 2018 on page 4. During open enrollment you can enroll or make changes to your coverage in the following plans:

- *Medical*
- *Dental*
- *Flexible Spending*
- *Voluntary Life Insurance*

**Deadline to submit forms:**
**December 15, 2017**

## Instructions: please choose one of the following

**1** **ENROLLED & DO NOT WISH TO MAKE CHANGES?**
Complete sections 1, 2, 3 & 4

**2** **ENROLLED & WISH TO CANCEL FOR YOURSELF OR DEPENDENT(S)?**
Complete sections 1, 2, 5, 6 & 7

**3** **NOT ENROLLED & DO NOT WISH TO ENROLL?**
Complete sections 1, 2 & 5

**4** **MAKE CHANGES TO COVERAGE?**
Choose from sections 6, 7 & 8 and complete necessary forms. Then complete sections 1, 2, 3 & 4

**5** **WISH TO ENROLL OR WISH TO ADD DEPENDENT(S)?**
Go to the TM Portal. Print and legibly complete enrollment forms for each type of coverage. Complete sections 1, 2, 3, 6 & 7

## FAQs

1. **When is the deadline to submit forms?** December 15, 2017
2. **What happens if I don't submit the forms on time?** Your coverage will stay exactly the same. You could lose coverage for yourself or an eligible dependent.
3. **What if I change my mind later in 2018?** Open enrollment is the only time of the year that you can make changes, cancel coverage, add eligible dependents, or add coverage.
4. **Who do I contact if I have questions?** Jenny Morris 512.418.0444 or jennymorris@wesellmeat.com

# 2018 Benefits Open Enrollment Elections Form

## Section 1: Employee Information

***Please make sure your personal information is up to date. Changes to your home address, phone number, etc. can be updated through your general manager or Jenny Morris (512) 418-0444 jennymorris@wesellmeat.com***

**Name:** ______________________________________________

**Phone#:** ___________________________ **Date of Birth:** ____________________

## Section 2: Health Flexible Spending Account (FSA)/Dependent Care (FSA)

*****By signing and enrolling in the FSA, I confirm I have been employed 1+ years with K&N Management.***

**Name:** ____________________________________________________ **Date of Birth:** ______________________

**Social Security Number:** __________________________________ **Phone Number:** ___________________________

**Address:** ____________________________________________________________________________________

**Eligible Health FSA Benefits:** ***The Health FSA Benefits Account has an annual minimum contribution of $250.00 and an annual maximum contribution limit of $2,000.00.***

Please check one ◯ I wish to direct $______________ for the upcoming year to my Health FSA

$______________ per pay period deduction amount ***(*HR use only)***

◯ Waive Coverage

****You are eligible for one additional card for either a spouse or a dependent. If you wish to receive an extra card, please complete the following information:***

Dependent's Full Name: ___________________________________ Social Security Number: ___________

Date of Birth: ___________________________________ Relationship to employee: _______________

**Eligible Dependent Care FSA Benefits:** ***The Dependent Care FSA Benefits Account has an annual minimum contribution of $250.00 and an annual maximum contribution limit of $5,000.00.*** I understand that any premiums I am obligated to pay for group health care coverage for myself and any of my dependents will be deducted from my pay on a BEFORE-TAX BASIS.

Please check one ◯ I wish to direct $______________ for the upcoming year to my Dependent Care FSA

$______________ per pay period deduction amount ***(*HR use only)***

◯ Waive Coverage

## Section 3: Premium Tax Conversion

Please check if you would like to enroll:

◯ ***Pre-Tax Election:*** Yes – I wish to participate in the Pre-Tax Plan. I authorize my employer to reduce my salary on a pre-tax basis to pay for the Medical, Dental and Vision premium for those benefits for which I have enrolled on this form.

***Acknowledgement:*** I acknowledge that my pre-tax elections cannot be changed once the plan year of January 1, 2018 to December 31, 2018 has begun unless there is a change in family status. A change in family status includes: changes in marital status, changes regarding dependents, changes in employment status, changes in residence or work site, changes in work schedule, or a dependent ceasing to satisfy the eligibility conditions for coverage.

## Section 4: Authorization/Signature

○ ***I do not wish to make any changes to my benefits coverage for the 2018 year.***

I understand that the above elections are effective for the calendar year of 2018 and may not be changed during the plan year unless I experience a Qualifying Event as defined by the IRS and supply the human resources department with the necessary documentation within 30 days of said event. I agree to abide by the regulations and terms of the plans I have enrolled in according to the summary plan descriptions for each plan. I authorize the plan administrator to deduct from my paycheck all appropriate premiums for my elections. I confirm that the information listed above is true and accurate.

**Employee Signature** ______________________________ **Date** ______________

**Employee Name** ______________________________

## Section 5: Waiver (refusal of coverage)

○ ***Waive Coverage***

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through K&N Management. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action. If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends. I understand that if the loss of coverage is Medicaid CHIP, I have 60 days to request special enrollment. If I have a new dependent as a result of marriage, birth, adoption, placement for adoption or suit for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, placement for adoption or suit for adoption.

**Employee Signature** ______________________________ **Date** ______________

**Employee Name** ______________________________

## Section 6: Health Insurance

Please check one:

○ Employee Only ○ Employee & Child(ren) ○ Employee & Spouse ○ Employee & Family ○ Waive Coverage

○ Cancel Coverage for myself ○ Cancel Coverage for my dependent(s)

***Note: If adding eligible dependents or newly enrolling you will need to print & complete the Health benefits enrollment form on the TM Portal.***

## Section 7: Dental Insurance

Please check one:

○ Employee Only ○ Employee & Child(ren) ○ Employee & Spouse ○ Employee & Family ○ Waive Coverage

○ Cancel Coverage for myself ○ Cancel Coverage for my dependent(s)

***Note: If adding eligible dependents or newly enrolling you will need to print & complete the Dental benefits enrollment form on the TM Portal.***

## Section 8: Voluntary Life Insurance (Salaried TMs Only)

Please check one:

○ I currently have Voluntary Life Insurance and wish to CANCEL coverage

○ I wish to enroll in voluntary Life Insurance (***print & complete the Voluntary Life form on the TM Portal***)

○ I do not wish to purchase extra life insurance at this time

| 2018 HOURLY Health Benefit Plan (BCBS) *weekly contribution | | | |
|---|---|---|---|
| Employee Only | Emp + Spouse | Emp + Child(ren) | Emp & Family |
| $16.61 | $191.34 | $95.22 | $220.36 |

| 2018 HOURLY Dental Benefit Plan (Delta) *weekly contribution | | | |
|---|---|---|---|
| Employee Only | Emp + Spouse | Emp + Child(ren) | Emp & Family |
| $6.57 | $16.65 | $16.65 | $16.65 |

| 2018 SALARY Health Benefit Plan (BCBS) *weekly contribution | | | |
|---|---|---|---|
| Employee Only | Emp + Spouse | Emp + Child(ren) | Emp & Family |
| $16.61 | $42.82 | $28.40 | $47.17 |

| 2018 SALARY Dental Benefit Plan (SunLife) *weekly contribution | | | |
|---|---|---|---|
| Employee Only | Emp + Spouse | Emp + Child(ren) | Emp & Family |
| $0.94 | $1.89 | $2.21 | $3.16 |