DG3 2024 Benefit Election Form

Employee Name				Social Security Number
Address		City		ST Zip
Gender	Marital Status	Annual Salary/Hourly Pay Rate		Home Phone Number
Date of Birth	Job Title	Date of Hire/Rehire	Hours per Week	Email Address

Medical Election | CIGNA | SEMI-MONTHLY Contributions Reference your Summary of Benefits and Coverage for detailed description of this coverage and **include your dependent information below.**

HDHP | HSA	Employee Only	Employee/Spouse	Employee/Children	Family
	☐ $88.75	☐ $186.36	☐ $168.63	☐ $266.26

☐ I waive Medical Coverage for myself and my dependents. Initials

☐ I am covered on another plan ☐Spouse on other plan ☐ Dependents on another plan.

Dental Election | SEMI-MONTHLY Contributions Reference your Summary of Benefits and Coverage for detailed description of this coverage and **include your dependent information below.**

CIGNA High Plan	Employee Only ☐ $21.94	Employee/Spouse ☐ $39.02	Employee/Children ☐ $37.08	Family ☐ $67.93
CIGNA Low Plan	Employee Only ☐ $19.75	Employee/Spouse ☐ $21.78	Employee/Children ☐ $18.06	Family ☐ $39.97
UHC DHMO	Employee Only ☐ $4.12	Employee/Spouse ☐ $8.28	Employee/Children ☐ $7.12	Family ☐ $14.78

☐ I waive Dental Coverage for myself and my dependents.

☐ I am covered on another plan ☐Spouse on other plan ☐ Dependents on another plan Initials

Dental Disclaimer If you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Cigna may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

Vision Election | SEMI-MONTHLY Contributions Reference your Summary of Benefits and Coverage for detailed description of this coverage and **include your dependent information below.**

CIGNA Vision	Employee Only	Employee/Spouse	Employee/Children	Family
	☐ $ 2.71	☐ $ 5.16	☐ $ 5.44	☐ $ 8.48

☐ I waive Vision Coverage for myself and my dependents. Initials

☐ I am covered on another plan ☐Spouse on other plan ☐ Dependents on another plan

Vision Disclaimer An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment. If the employee elects not to enroll in the vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

Basic Life/AD&D Insurance Coverage | NY Life | Based on Class

You are automatically enrolled once you satisfy your waiting period. Please reference your basic life benefit summary for detailed description of this coverage. **Please include your beneficiary information below.**

Voluntary Life	Employee Option	Spouse Option	Child Option
Employee: If newly eligible no health questions for up to $200,000 Spouse: If newly eligible no health questions for up to $30,000 Child: If newly eligible no health questions up to $10,000	☐ $10,000 increments up to $500,000 $_____ Amount elected	☐ $5,000 increments up to $250,000 $_____ Amount elected	☐ 6 months to 26 years: flat $10,000 $_____ Amount elected

☐ I waive Voluntary Life Coverage for myself and my dependents Initials

BENEFICIARY DESIGNATION FOR LIFE AD&D – Beneficiary(ies) can be updated throughout the year. Complete this portion of the form if there is a change to your designation. If you are electing voluntary life in addition to the employer paid basic life, **please provide confirmation that same beneficiary(ies) is intended for the voluntary coverages.**

Primary Beneficiary Name	**Social Security Number**	**Relationship**	**Gender**	**Date of Birth**	**Share** (Must equal 100%)
Secondary Beneficiary Name	**Social Security Number**	**Relationship**	**Gender**	**Date of Birth**	**Share** (Must equal 100%)

BENEFICIARY ADDRESS / TELEPHONE

Beneficiary Name	Address / Telephone	If different, please provide below
	☐ same as employee	
	☐ same as employee	
	☐ same as employee	
	☐ same as employee	

Voluntary Long-Term Disability | NY Life | Employee Paid ☐ **I am enrolling in this coverage.**
Benefit if disabled – 60% up to $10,000/month ☐ **I am waiving this coverage.**
Please reference your long-term disability benefit summary for detailed description of this coverage

COVERED FAMILY MEMBERS & ELECTIONS Check the benefit category elected for each family member

Family Member Name	Relationship	SSN	Birthday	Gender	Medical	Dental	Vision	Vol Life
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

COVERED FAMILY MEMBERS ADDRESS

Family Member Name	Address / Telephone	If **different**, please provide below
	☐ same as employee	
	☐ same as employee	
	☐ same as employee	
	☐ same as employee	

Payroll Deduction Authorization for Health Savings Account – I hereby authorize DG3 to make the following Deduction(s) as a contribution to the Health Savings Account from my earnings. Please note, any amount you contribute cannot exceed the IRS contribution maximum

$_____ to be deducted, pre-tax, with each pay period. IRS Maximums for 2024: $4,150 for Single and $8,300 for Family

Payroll Deduction Authorization for Flexible Spending Account and/or Dependent Care Flexible Spending Account – I hereby authorize DG3 to make the following Deduction(s) as a contribution to the Flexible Spending Account of my choice from my earnings.

$_____ to be deducted, pre-tax, with each pay period. IRS Maximums for 2024: $3,200 for Medical FSA.

$_____ to be deducted, pre-tax, with each pay period. IRS Maximums for 2024: $5,000 for Dependent Care FSA

Waiver - Signature

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Employee signature if **WAIVING** medical, dental and/or vision coverage Date

Electing - Signature

In accordance with my rights under the Plan, I elect the benefits indicated and designate the necessary amounts for each benefit I have selected for the plan year specified above. The employer and I agree that my cash compensation will be redirected by the amounts set forth for each pay period and plan year (or during such portion of the year as remains after the date of this agreement). I understand that my elections are for the plan year commencing **January 1, 2024,** and that my elections may be changed only during open enrollment each year.

I agree that my employer may deduct premiums from my pay or add premiums to my dues, if they are required for the coverages I have chosen above. I confirm that the information I have provided on this form is complete and accurate. **I understand:** that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description; there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan; that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law; that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes; any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex. Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet. If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. NY Life or its designee has the right to reject your request. I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice. Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Employee Signature Date