2027 Benefit Election Form

DG3 NORTH AMERICA | NON-UNION EMPLOYEES

Plan year January 1 – December 31, 2027

Open Enrollment runs December 7 – 18, 2026. Complete this form only if you are making a change – if you're happy with your current elections, no form is needed. **Exception: HSA and FSA elections do not roll over –** complete the last section to contribute in 2027. Return your form to Human Resources by **December 18, 2026.**

EMPLOYEE INFORMATION

EMPLOYEE NAME (PLEASE PRINT)		SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS		CITY	STATE / ZIP
GENDER	MARITAL STATUS	ANNUAL SALARY / HOURLY RATE	PHONE NUMBER
JOB TITLE	DATE OF HIRE / REHIRE	HOURS PER WEEK	EMAIL ADDRESS
REASON FOR THIS FORM ☐ Open enrollment change ☐ New hire ☐ Qualifying life event: _____			EVENT / EFFECTIVE DATE

MEDICAL COVERAGE – SEMI-MONTHLY PRE-TAX CONTRIBUTIONS NEW LOW-COST OPTION FOR 2027

Your cost per paycheck (24 pay periods). DG3 pays 79% of the medical premium. Choose one plan and coverage level, and list covered dependents in the Covered Family Members section.

MEDICAL PLAN	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Anthem HDHP with HSA Blue Access PPO network • $6,200 / $12,400 deductible DG3 HRA + HSA contribution • 0% after deductible	☐ $122.87	☐ $296.12	☐ $210.85	☐ $381.89
Apex-MEC Plus Advantage NEW Limited benefit plan – not major medical; not HSA-eligible Includes Globe Life hospital indemnity and group term life	☐ $14.76	☐ $29.78	☐ $29.07	☐ $43.57

☐ **I waive Medical coverage for myself and my dependents.**

☐ I am covered on another plan ☐ Spouse/DP on another plan ☐ Dependents on another plan

Initials: _____

DENTAL COVERAGE – SEMI-MONTHLY PRE-TAX CONTRIBUTIONS

DENTAL PLAN	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Anthem High Plan $25 / $75 deductible • $1,500 annual max Dental Complete network	☐ $23.45	☐ $41.71	☐ $39.64	☐ $72.62
Anthem Low Plan $50 / $150 deductible • $1,500 annual max ($1,000 out-of-network) Dental Complete network	☐ $26.60	☐ $29.33	☐ $24.33	☐ $54.06
UHC DHMO No deductible • fixed copays Must use a UHC network dentist	☐ $5.05	☐ $10.15	☐ $8.73	☐ $18.12

☐ **I waive Dental coverage for myself and my dependents.**

☐ I am covered on another plan ☐ Spouse/DP on another plan ☐ Dependents on another plan

Initials: _____

VISION COVERAGE – SEMI-MONTHLY PRE-TAX CONTRIBUTIONS

VISION PLAN	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Anthem Blue View Vision $20 exam / $20 lenses • $150 frame or contact allowance	☐ **$1.88**	☐ **$3.58**	☐ **$3.78**	☐ **$5.89**

☐ **I waive Vision coverage for myself and my dependents.** **Initials: _____**

☐ I am covered on another plan ☐ Spouse/DP on another plan ☐ Dependents on another plan

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. Anthem 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 disclaimer: Your decision to elect or not elect vision coverage must be kept until the next Open Enrollment. If you do not enroll in vision coverage, you are not eligible to enroll until the plan's next Open Enrollment period.

COVERED FAMILY MEMBERS & ELECTIONS

List each family member you are covering and check each benefit they should be enrolled in. Dependents include your legal spouse or domestic partner and children to age 26. Attach documentation for any newly added dependent.

Family member name	Relationship	SSN	Date of birth	Gender	Medical	Dental	Vision	Vol. Life
Spouse / Domestic Partner:					☐	☐	☐	☐
Child:					☐	☐	☐	☐
Child:					☐	☐	☐	☐
Child:					☐	☐	☐	☐

Family member name	Address	If different from employee, address / telephone
	☐ Same as employee	
	☐ Same as employee	
	☐ Same as employee	
	☐ Same as employee	

BASIC LIFE AND AD&D – GUARDIAN | PAID BY DG3

You are automatically enrolled once you satisfy your waiting period – no election needed. Coverage is 1.5x your annual salary, up to $500,000, and includes AD&D. Please complete your beneficiary information below.

VOLUNTARY LIFE AND AD&D – GUARDIAN | EMPLOYEE PAID

To cover your spouse or children, you must also elect coverage for yourself. Your cost is based on your age and the amount you elect – see the 2027 Benefit Guide.

Coverage	Options	Guaranteed issue*	Amount elected
Employee	$10,000 increments up to $400,000	**$200,000**	☐ $_____
Spouse / Domestic Partner	$5,000 increments up to $200,000 (ends at age 70)	**$30,000**	☐ $_____
Child(ren)	$10,000 flat – birth to age 26	**$10,000**	☐ $_____

**Guaranteed issue applies when you first become eligible – no health questions up to these amounts. If you previously waived coverage, or elect more than these amounts, Guardian will require Evidence of Insurability (health questions), and premiums begin after approval. Benefits reduce 35% at age 70 and 50% at age 75. Amounts shown are for non-union employees.*

☐ **I waive Voluntary Life coverage for myself and my dependents.** **Initials: _____**

BENEFICIARY DESIGNATION – LIFE AND AD&D

Beneficiaries can be updated anytime during the year. Complete this section only if you are changing your designation. Unless you indicate otherwise, the same beneficiaries apply to Basic and Voluntary Life. Shares for each level must total 100%.

Beneficiary name	Level	SSN	Gender	Relationship	Date of birth	Share %
	Primary					
	Primary					
	Contingent					
	Contingent					

Beneficiary name	Address	If different from employee, address / telephone
	☐ Same as employee	
	☐ Same as employee	
	☐ Same as employee	
	☐ Same as employee	

VOLUNTARY LONG-TERM DISABILITY – GUARDIAN | EMPLOYEE PAID

Replaces 60% of your salary, up to $10,000 per month

Benefits begin after a 90-day waiting period and can continue up to Social Security normal retirement age. Enrolling after you previously waived requires Evidence of Insurability.

☐ **I am enrolling in this coverage**

☐ **I am waiving this coverage**

HSA AND FSA ELECTIONS – REQUIRED EACH YEAR ELECTIONS DO NOT ROLL OVER

Account	Pre-tax deduction (24 pay periods)	2027 IRS maximum
Health Savings Account (HSA) Anthem HDHP enrollees only	$_____ per pay period	$4,500 single / $9,000 family, including DG3's $500 / $1,000 (deposited at the start of each quarter). +$1,000 catch-up at age 55+.
Health Care FSA (WEX) Not available if you contribute to an HSA	$_____ per pay period	$3,500 per year. Carryover: up to $680 of 2026 funds into 2027; up to $700 of 2027 funds into 2028
Limited Purpose FSA (WEX) Dental and vision only – can pair with an HSA	$_____ per pay period	$3,500 per year. Carryover: up to $680 of 2026 funds into 2027; up to $700 of 2027 funds into 2028
Dependent Care FSA (WEX) Child care for children under 13 or adult dependent care	$_____ per pay period	$7,500 per household

I authorize DG3 to deduct the amounts above from my pay, pre-tax, each pay period. My total contributions may not exceed the IRS maximum. I may change my HSA contribution at any time; FSA elections can change only with a qualifying life event.

WAIVER OF COVERAGE – SIGNATURE

I understand that if I and/or my dependents waive coverage and want to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the 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 (60 days after losing Medicaid or CHIP coverage or becoming eligible for Medicaid/CHIP premium assistance). 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

ELECTION AUTHORIZATION – 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, 2027, and that my elections may be changed only during open enrollment each year, or within 30 days of a qualifying life event.

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 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 I have incurred, may not be covered by my health benefit plan; 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, and may be combined with other information so that it is no longer individually identifiable and used for commercial and other purposes. 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, 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 set forth in the applicable benefit booklet. If coverage is waived and I later decide to enroll, late entrant penalties may apply, and I may have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my 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.

NOTICE: Any person who, with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, 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

Return your completed form to Human Resources by December 18, 2026. Questions about your benefits? Call the Oswald Benefits Concierge at 216-206-6798 or email mybenefits@oswaldcompanies.com – every call and email is acknowledged within 24 hours. Se habla español (by appointment).