Mt. Gilead Exempted Village School District

Employee Benefit Election Form

❑ Enroll ❑ Cancel/Terminate ❑ Change

Reason for Enrollment / Termination / Change: _____

Full Name _____ **Social Security #** _____

Address _____ **Gender** ❑ M ❑ F **DOB** _____/_____/_____

City _____ **ST**_____ **Zip**_____ **Marital Status** ❑ Single ❑ Married ❑ Divorced

Home Phone _____ **Employment or Termination Date** _____/_____/_____

Employment Status (Active or Retired)_____ **Full Time Y or N** _____ **Salary (yearly)** _____

Hours worked per week: _____ **Change date (birth or marriage)** _____/_____/_____

Email Address: _____ **Requested EFFECTIVE Date:** _____/_____/_____

Authorized to work and reside in the United States Y or N _____

Make your selection by placing a "✓" in the appropriate coverage boxes and complete the "***Dependent Information***" if applicable.

Medical	❑ Employee Only	❑ Employee & Spouse	❑ Employee & Child(ren)	❑ Family	❑ Waive medical*
Dental	❑ Employee Only	❑ Employee & Spouse	❑ Employee & Child(ren)	❑ Family	❑ Waive Dental
Vision	❑ Employee Only	❑ Employee & Spouse	❑ Employee & Child(ren)	❑ Family	❑ Waive Vision

***IF WAIVING MEDICAL, REASON FOR WAIVING:** _____

Dependent Information

_____ ❑ M ❑ F ___/___/___ _____
Spouse's Full Name — Date of Birth — Social Security No.

_____ ❑ M ❑ F ___/___/___ _____
Child's Full Name Student ❑ Yes ❑ No — Date of Birth — Social Security No.

_____ ❑ M ❑ F ___/___/___ _____
Child's Full Name Student ❑ Yes ❑ No — Date of Birth — Social Security No.

_____ ❑ M ❑ F ___/___/___ _____
Child's Full Name Student ❑ Yes ❑ No — Date of Birth — Social Security No.

Authorization of Deductions under "Section 125"

I authorize my employer to redirect "pre-tax" funds from my salary each month as payment towards my eligible Medical Group Insurance Premiums. I understand that I will receive written notification of any increases in the amounts deducted. I understand I have thirty (30) days after receiving such notification to reelect my insurance options and that I must sign this authorization prior to the effective date of my initial redirection. I understand that I cannot change my decision until the beginning of each plan year. The exception to this is a change in family status (qualifying event), such as: a change in your number of tax dependents, marriage, divorce, legal separation, birth, adoption of a child or placement for adoption, death of a spouse, a change in your spouse's employment, a change in your dependent's eligibility, such as when a child reaches age 13 and no longer qualifies for coverage under a Dependent Care FSA, a change in child/elder care cost or coverage, but this only applies to those who use a Dependent Care FSA, COBRA Qualifying events, Judgment Decrees or Orders, Entitlement to Medicare and FMLA (Family Medical Leave Act). Please refer to your Summary Plan Description for details. Should you desire to deduct your costs on an "after tax" basis, please contact the HR Department for a Section 125 waiver.

Basic Life & AD&D: AUL 00610712-0180-000
Voluntary Term Life Insurance: AUL G00610712-0180-000

Mt. Gilead Exempted Village provides a 100% company-paid Basic Life Insurance and AD&D for all full-time employees who have completed their eligibility period. Associates are enrolled to receive Basic Life Insurance Coverage and are required to complete the Beneficiary Designation information below (attach additional sheet if necessary). In addition you may also purchase additional life insurance for yourself and dependents. The additional voluntary life insurance is 100% employee paid. Please refer to enclosed cost sheet to determine your premium amount and indicate your selection below.

Employee Occupation / Job Class: _____

VL-Voluntary Employee Life **Accept** **Waive** $_____
(Min. $10,000. Increments of $10,000 up to 5x salary; amounts elected above the $200,000 will require an evidence of insurability

VS-Voluntary Spouse Life **Accept** **Waive** $_____ Option1 Option2 Option3 Option4
Spouse: $5,000 increments up to 50% of employee will need to complete an evidence of insurability for amounts above $20,000.

VC-Voluntary Child(ren) Life **Accept** **Waive** $_____ Option1 Option2 Option3 Option4
Dependent Child(ren): Amount must not exceed 50% of spousal election.

Check if Beneficiary is for: All Policies Basic Life & AD&D Voluntary Term Life

Primary Beneficiary Designation (if none specified, death benefits will be paid according to state statutes and contract language):

First Name & MI Last	SS#	Relationship	% of Benefit	

Contingent Beneficiary Designation (if none specified, death benefits will be paid according to state statutes and contract language):

First Name & MI Last	SS#	Relationship	% of Benefit	

If percentages don't total 100%, death benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, death benefits will be distributed equally.

I understand if I decline any of the above coverage's, enrollment of the coverage at a later date will require Evidence of Insurability at my own expense.

- I hereby apply for all insurances as indicated above and on any attached applications, for which I am eligible or may become eligible.
- I authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I authorize the insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.
- If contributions are required, I authorize my employer to deduct premiums from my pay. If my pay rate or elections change during the year, I authorize my employer to change the deducted premiums.
- The information provided above is true and correct to the best of my knowledge.
- 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.
- **Review the Notices and Limitations.** Visit www.employeebenefits.aul.com to find the Notices and Limitations, G-14320 (Pre05) 12/28/12. Go to Forms, Policy/Employee Admin, and Notices and Limitations.

SIGNATURE_____ **DATE**_____