USHydrations
WE MAKE YOUR BRAND

OFFICE USE ONLY:
____ HR/Payroll: _____
Initial Date Received

2017-2018 Contribution Rates & Benefit Election Form

Employee Name: _____ Social Security (last 4 digits): _____

Date of Hire: _____ Enrollment Eligibility Date: _____

EMPLOYEE BENEFIT(S) ELECTION

(Please check all that apply and select the level of coverage) All rates listed below are deducted on a semi-monthly basis.

Geisinger Health Plan

☐ I **Waive/Decline** this benefit.**	**Rate**
☐ Employee Only	$ 76.72
☐ Employee + Spouse/Domestic Partner	$ 182.61
☐ Employee + Child	$ 120.23
☐ Employee + Children	$ 171.09
☐ Family	$ 210.35
☐ Tobacco Surcharge †	$ 9.97

Highmark Davis Vision Plan

☐ I **Waive/Decline** this benefit.	**Rate**
☐ Employee Only	$ 2.09
☐ Family	$ 5.42

†The tobacco surcharge applies to participating employees who have certified their status as a tobacco user and have not completed a tobacco cessation program.

Guardian Dental Basic Plan #1

☐ I **Waive/Decline** this benefit	**Rate**
☐ Employee Only	$ 10.23
☐ Employee + Spouse/Domestic Partner	$ 23.91
☐ Employee + Child(ren)	$ 25.05
☐ Family	$ 38.34

OR

Guardian Dental Premium Plan #2

☐ I **Waive/Decline** this benefit.	**Rate**
☐ Employee Only	$ 14.45
☐ Employee + Spouse/Domestic Partner	$ 31.44
☐ Employee + Child(ren)	$ 33.53
☐ Family	$ 47.97

Guardian Short Term Disability

☐ I **Waive/Decline** this benefit.
☐ I elect to enroll in this benefit.

Guardian Long Term Disability

☐ I **Waive/Decline** this benefit.
☐ I elect to enroll in this benefit.

*HEALTH INSURANCE BENEFIT WAIVER***

I acknowledge I have been offered health insurance from my employer, USHydrations. I hereby waive health insurance coverage for myself and/or my eligible dependents for the current plan year. I attest that I and/or my dependents, for whom I am waiving coverage, are currently covered under another health insurance plan. I understand by waiving coverage, I may not re-enroll either myself and/or my dependents in the Company's health insurance until the following plan year except for a qualifying event. I understand I must provide proof of existing, comparable health care coverage and certify my status as a non-tobacco user in order to receive the monthly benefit stipend offered by USHydrations.

Name of Insurance Provider: _____
Type of Coverage: _____
Group Number: _____
Coverage Effective Dates: _____ to _____
Subscriber Name: _____
Dependents Names: ***(only applicable if employee is the subscriber) ****

_____ _____

_____ _____

THIS SECTION TO BE COMPLETED BY EMPLOYER:

Proof of existing comparable coverage for:
Employee Only ☐ YES ☐ NO
Eligible Dependents * ☐ YES ☐ NO

☐ Eligible for monthly benefit stipend

☐ Not Eligible for monthly benefit stipend

By signing this form, I certify the information I provided above is true and accurate. I understand that completion of this form does not guarantee coverage under the selected benefits. A separate application/enrollment form must be completed and evaluated by the insurance carrier for the benefit(s) that I have selected under the Plan. I authorize my employer to deduct from my paycheck the deductions indicated above. I understand that these elections are irrevocable for the plan year commencing on October 1, 2017 and ending on September 30, 2018 unless I have a qualifying circumstance in accordance with Internal Revenue Code Section 125 and must notify my employer to change my benefit(s) within the time specified by my employer.

Employee Signature: _____ Date Signed: _____

Directions: To ensure timely processing, this form and any applicable documentation should be submitted to the Human Resource Department at least 3 days prior to the enrollment eligibility date.