Employee Name:		Sherwood Manageme	nt Co., Inc Health and [Dental Benefits - Election	Form	
Part 1 - Medical Coverage - If you want to participate in one of the medical coverage programs, complete this part AND, if selected, the separate enrolment form(s) provided by Kaiser Permanente. Select A, B 'OR' C Below For Medical Benefits	Employee Name:					
Select A, B 'OR' C Below For Medical Benefits Rates shown are the employee's cost of Insurance PER PAYCHECK Employee NUY Employee PLUS 1 Full Family (A) Kaiser Permanente – PPO \$236.11 \$734.53 \$1.127.36 \$ [B) Enrollment in Health Reimbursement Arrangement (HRA) Account (additional material provided): (C) NO Medical Coverage and NOT enrolling in Health Reimbursement Arrangement (HRA): (If NO medical coverage is being selected, please ALSO check ONE of the reasons below: (Coverage wi spouse's employer Private coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc (please of the private coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc (please of the private coverage (non-group) Other PayCHECK Employee ONLY Employee Oncore (please of the private of insurance PER PAYCHECK Employee Oncore (please of the private of the dental coverage programs, complete this part AND the separate enrollment form(s) provided by Guardian. Select ONE Below for Dental Benefit Coverage Rates shown are the employee's Cost of Insurance PER PAYCHECK Employee ONLY Employee's place of the selection of the dental coverage (please ALSO) of the private coverage (please ALSO) o	Date of Hire: Eligible as of:					
Rates shown are the employee's cost of insurance PER PAYCHECK Employee ONLY Employee PLUS Full Family				verage programs, comple	te this part AND, if selected, the	
Employee ONLY Employee PLUS 1 Full Family		Select	A, B *OR* C Below For	Medical Benefits		
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If NO medical coverage is being selected, please ALSO check ONE of the reasons below: Coverage w/ parent Private coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc (please specify): Part 2 - Dental Coverage - If you want to participate in one of the dental coverage programs, complete this part AND the separate enrollment form(s) provided by Guardian. Select ONE Below for Dental Benefit Coverage Rates shown are the employee's cost of insurance PER PAYCHECK Employee ONLY Employee'Spouse Employee'Child Full Family Assurant DHMO \$5.99 \$10.00 \$13.50 \$15.77 \$ Assurant PPO - Low Option \$11.72 \$22.37 \$24.24 \$36.15 \$ NO Dental Coverage If NO dental coverage is being selected, please ALSO check ONE of the reasons below: Coverage w/ spouse's employer Private coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc Coverage w/ parent PART 3 - FCA Enrollment - Wes, enroll me in the Flexible Contribution Account. I understand that I cannot change my premium deduction until the beginning of the next open enrollment period, except as allowed for adding an eligible dependent because of birth, marriage or adoption-or-deleting an enrolled dependent due to death or divorce. No, DO NOT enroll me in the Flexible Contribution Account. I understand that by waiving participation at this time, I will not have the opportunity to participate again in this plan until the next open enrollment period. Signature: Date: Date: Date: Part 1 - Payroll Deduction Authorization - Your signature below authorizes Sherwood Management to deduct the employee's premium for the benefits selected above from each pay check (deductions will begin with the first pay check in the month for which coverage is effective). When your employment with Sherwood Management ends, a deduction from your final pay check will be made to cover all regularly scheduled, per paycheck deductions for the month for which coverage is effective). When your employment with the end of the calendar month you terninate your denient pro	(B) Enrollment in Hea	Ith Reimbursement Arran				
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Assurant PPO – High Option \$11.72 \$22.37 \$32.42 \$36.15 \$ PPO – High Option \$20.27 \$37.71 \$44.31 \$661.75 \$ NO Dental Coverage \$\text{NOP} = \text{MediCare}\$. Retiree, etc. (please ALSO check ONE of the reasons below: Coverage w/ spouse's employer Private coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc. (please specify): Part 3 – FCA Enrollment — Yes, enroll me in the Flexible Contribution Account. I understand that I cannot change my premium deduction until the beginning of the next open enrollment period, except as allowed for adding an eligible dependent because of birth, marriage or adoption -or- deleting an enrolled dependent due to death or divorce. No, DO NOT enroll me in the Flexible Contribution Account. I understand that by waiving participation at this time, I will not have the opportunity to participate again in this plan until the next open enrollment period. Signature: Date: Part 4 – Payroll Deduction Authorization - Your signature below authorizes Sherwood Management to deduct the employee's premium for the benefits selected above from each pay check (deductions will begin with the first pay check in the month for which coverage is effective). When your employment with Sherwood Management ends, a deduction from your final pay check will be made to cover all regularly scheduled, per paycheck deductions for the month in which you are terminated AND you will continue to be covered by the programs you are enrolled in until the end of the calendar month you terminate your employment in. Signature: Date: Date: Waiver of Benefits - If you selected NO COVERAGE for EITHER the medical or dental benefit programs, or both, your signature below signifies your acknowledgement of the availability of these programs and your desire not to participate in the program (s) marked NO COVERAGE.		\$5.99	\$10.00	\$13.50	\$15.77	
NO Dental Coverage If NO dental coverage is being selected, please ALSO check ONE of the reasons below:		\$11.72	\$22.37	\$24.24	\$36.15	
If NO dental coverage is being selected, please ALSO check ONE of the reasons below: Coverage w/ spouse's employerPrivate coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc (please specify):		\$20.27	\$37.71	\$44.31	\$61.75	
Coverage w/ spouse's employer Private coverage (non-group) Other Group Coverage, e.g., MediCare, Retiree, etc MediCal (please specify): MediCare, Retiree, etc MediCal (please specify): MediCare, Retiree, etc MediCal (please specify): MediCare, Retiree, etc MediCare MediCare (please specify): MediCare MediCare (please specify): MediCare MediCare (please specify): Medicare (please		1	NO Dental Coverage			
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signifies your acknowledgement of the availability of these programs and your desire not to participate in the program (s) marked NO COVERAGE.	Signature:Date:					
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