Sherwood Management Co., Inc. - Health and Dental Benefits - Election Form

Employee Name: _____ Store: _____

Date of Hire: _____ Eligible as of: _____

Part 1 - Medical Coverage - If you want to participate in one of the medical coverage programs, complete this part AND the separate enrollment form(s) provided by Kaiser Permanente.

Select ONE Below For Medical Benefit Coverage Rates shown are the employee's cost of insurance PER PAYCHECK			
	Employee ONLY	**Employee PLUS 1**	**Full Family**
Kaiser Permanente – DHMO SCR: HMO - Low Deductible	$51.00 _____	$207.08 _____	$328.41 _____
Kaiser Permanente – Dual Choice HMO SCR - $20/Co-Pay	$73.05 _____	$253.61 _____	$395.00 _____
NO Medical Coverage _____			

If NO medical 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 _____ MediCal (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 _____
Assurant PPO – High Option	$20.27 _____	$37.71 _____	$44.31 _____	$61.75 _____
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 _____ MediCal (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: _____

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.

Signature: _____ Date: _____

Rates Effective 4/1/2013; revised 4/3/14