BENEFIT/CHANGE ELECTION FORM

Plan year: January 1, 2026 – December 31, 2026

DECOTIIS
DeCotiis, FitzPatrick, Cole & Giblin, LLP

1. EMPLOYEE INFORMATION

Name (please print):	Employee Number:	Social Security Number:	Gender:
Address:	Date of Birth:	Date of Hire:	
City:	State:	Zip:	
Home Phone Number:	Cell Phone Number:	Email Address:	
Benefits effective date:			

_____

2. MEDICAL/PRESCRIPTION INSURANCE: CIGNA

Chosen benefits are effective 1st of the month following date of hire.

Plan Options	Waive Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Open Access Plus (OAP) (Option #1)	☐	☐ $411.80 semi-monthly	☐ $1,018.47 semi-monthly	☐ $901.47 semi-monthly	☐ $1,438.75 semi-monthly
Open Access Plus (OAPIN) (Option #2)	☐	☐ $125.65 semi-monthly	☐ $509.62 semi-monthly	☐ $424.90 semi-monthly	☐ $774.39 semi-monthly
HSA Open Access Plus (Option #3)	☐	☐ $46.03 semi-monthly	☐ $342.98 semi-monthly	☐ $274.11 semi-monthly	☐ $534.90 semi-monthly

Please mark one of the following boxes with "✓"

☐ I am electing coverage and I am not married.

☐ I am electing coverage and my spouse **does not** have availability of other coverage through employment.

☐ I am electing coverage and my spouse **does** have availability of other coverage through employment.

☐ I hereby waive Medical/Rx coverage offered to me, and am **not covered** under another plan.

☐ I hereby waive Medical/Rx coverage offered to me, as I am **covered** under another plan.

Source of Other Coverage (i.e. through Spouse, individual, other employer, etc.): _____

Carrier: _____ **Policy Number:** _____ **Subscriber Name:** _____

3. DENTAL INSURANCE: DELTA DENTAL

Chosen benefits are effective 1st of the month following date of hire.

Plan Options	Waive Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental PPO	☐	☐ $0.00	☐ $26.42 semi-monthly	☐ $22.36 semi-monthly	☐ $47.59 semi-monthly
Dental DHMO	☐	☐ $0.00	☐ $6.99 semi-monthly	☐ $12.29 semi-monthly	☐ $21.41 semi-monthly

If electing the Dental DHMO please visit **www.deltadentalins.com** to select a primary care dentist or call Delta Dental at **800-422-4234.**

DHMO Provider Selection: _____

4. VISION INSURANCE: VISION SERVICE PLAN (VSP)

Chosen benefits are effective 1st of the month following date of hire.

Plan Options	Waive Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
VSP Vision Plan	☐	☐ $0.72 semi-monthly	☐ $1.15 semi-monthly	☐ $1.18 semi-monthly	☐ $1.90 semi-monthly

5. DEPENDENT ENROLLMENT INFORMATION

First & Last Name	Gender	Relationship (SPOUSE, DP, Child)	Date of Birth (MM/DD/ YYYY)	Social Security Number (required)	ADD/ CANCEL COVERAGE	Select Plan(S) TO ADD/ CANCEL
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision

6. HEALTH SAVINGS ACCOUNT (HSA): HSABANK

Chosen benefits are effective 1st of the month following date of hire.

If you elect to participate in the Cigna HSA OAP Plan, you may contribute funds to an HSA on a pre-tax basis. The annual HSA contribution maximums are **$4,400 for Employee Only Coverage** and **$8,750 for all other coverage levels**. If you are age 55 or older, you may contribute an additional **$1,000** (regardless of the coverage level you elected).

Please Note: HSABank charges a monthly administrative fee of $2.30

If you are interested in participating in an HSA, please check the box below and list your **annual** and **per pay** contribution amounts. Please note, there are 24 pay periods per year.

☐ **YES**, I would like to participate in the Health Savings Account through HSABank

My ANNUAL Contribution: $____________________ **My PER PAY Contribution: $ ____________________**

7. FLEXIBLE SPENDING ACCOUNTS (FSA): ASURE

Chosen benefits are effective 1st of the month following date of hire.

☐ **NO**, I do not wish to participate in the Flexible Spending Accounts.

☐ **YES**, I elect to participate in the following Flexible Spending Accounts:

☐ **HEALTHCARE FSA** (out-of-pocket medical, dental and vision expenses for you and your dependents)

Minimum Election: $150.00 **Maximum Election: $2,850**

Amount Per Pay Period: ____________________ **x** **24 Pay Periods** **=** **Annual Election:** ____________________

☐ **DEPENDENT CARE FSA** (out-of-pocket day care expenses)

Minimum Election: $250.00

Maximum Election: $5,000 (Single/Married Filing Jointly)
$2,500 (Married Filing Separately)

Amount Per Pay Period: ____________________ **x** **24 Pay Periods** **=** **Annual Election:** ____________________

☐ **PARKING - Maximum Election: $280 per month**

Monthly Election: ____________________

☐ **TRANSIT - Maximum Election: $280 per month**

Monthly Election: ____________________

8. OPTIONAL LIFE INSURANCE - EMPLOYEE: UNUM

Chosen benefits are effective 1st of the month following date of hire.

Maximum optional coverage: $500,000
Evidence of Insurability (EOI) will be required if you are electing or increasing coverage anytime other than when you are eligible as a new hire.

Please mark one of the following boxes with "✓"

☐ **No**, I do not wish to elect Optional Life Coverage.

☐ **Yes**, I elect the following Employee Optional Life Coverage (max coverage is $500,000)
- Increments of $10,000, not to exceed 5x salary, up to the max coverage

Amount of Coverage Requested: _____

Any amount over $200,000 requires Evidence of Insurability (EOI)

You must elect Voluntary Employee Life to participate in the following Voluntary Spouse and Child(ren) Life Plans. Employee is responsible for 100% of the premium.

Employee & Spouse Optional Life Coverage Monthly Premium	
Age	**Cost per $1,000**
15-24	$0.06
25-29	$0.06
30-34	$0.08
35-39	$0.11
40-44	$0.16
45-49	$0.27
50-54	$0.41
55-59	$0.50
60-64	$0.78
65-69	$1.00
70-74	$3.76
75+	$3.76

Please Note: Amount of Life Insurance available, if you become insured at a certain ages, or have reached certain ages while insured can be reduced.

- If you have reached age 65, but not age 70, your amount of life insurance will be:
  - 65% of the amount of life insurance you had prior to age 65; or
  - 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70.
- If you have reached age 70 or more, your amount of life insurance will be:
  - 50% of the amount of life insurance you had prior to your first reduction; or
  - 50% of the amount of life insurance shown above if you become insured on or after age 70

9. OPTIONAL LIFE INSURANCE - SPOUSE: UNUM

Chosen benefits are effective 1st of the month following date of hire.

Maximum optional coverage: $500,000 **(amounts over $25,000 subject to EOI)**

Please mark one of the following boxes with "✓"

☐ **No**, I do not elect to purchase life insurance for my spouse

☐ **Yes**, I elect to purchase life insurance for my spouse
- Increments of $5,000; Increments not to exceed the employee's elected amount
- Rates are same as employee rates - age based on age of employee

Amount of Coverage Requested: _____

10. OPTIONAL LIFE INSURANCE - CHILD(REN): UNUM

Chosen benefits are effective 1st of the month following date of hire.

Please mark one of the following boxes with "✓"

☐ **No**, I do not elect to purchase life insurance for my child(ren)

☐ **Yes**, I elect to purchase life insurance for my child(ren)
- Increments of $2,000, up to $10,000 not to exceed the employee's elected amount
- Rates are $0.24 per $1,000 of coverage

Amount of Coverage Requested: _____

11. OPTIONAL SHORT-TERM DISABILITY (STD): GUARDIAN

Chosen benefits are effective 1st of the month following date of hire.

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of our salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

☐ 60% of salary to a maximum of $2,000
☐ I do not want this coverage

12. OPTIONAL ACCIDENT COVERAGE: GUARDIAN

You must be enrolled to cover your dependents. Chosen benefits are effective 1st of the month following date of hire.

	Waive Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Your Semi-Monthly Premium	☐	☐ $7.35	☐ $11.32	☐ $11.40	☐ $15.36

13. OPTIONAL 401(K) RETIREMENT PLAN: PRINCIPAL

Enroll at anytime. If chosen, benefits effective 1st of month following a full calendar month from date of hire. You must go onto the Principal website and enroll your contribution amount with Principal, as well as email Ellen Brewster with your contribution amount.

Please mark one of the following boxes with "✓"

☐ No, I do not wish to enroll in the 401(k) retirement plan.
☐ Yes, I wish to enroll in the 401(k) retirement plan.

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the Plan Year, unless there is a change in family status, under the terms of the Plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through DeCotiis, FitzPatrick, Cole & Giblin, LLP during the open enrollment period each year and during the year within 30 days of a qualified change in status.

By enrolling in medical, dental, vision and/or flexible spending account coverage, I am authorizing the Firm to take the necessary contributions from my salary for the benefits in which I have enrolled on a BEFORE-TAX basis. I understand benefits choices will be irrevocable (with the exception of the transit account) for the coming Plan Year unless I have a change in family status or elect to have my contributions taken from my pay on an AFTER-TAX BASIS. Prior to December 31 of each year, I will be offered the opportunity to elect coverage for the following Plan Year. If I do not complete and return a new Benefit Election Form at that time, I will be treated as having elected to continue all before-tax benefits under the Plan for the following Plan Year, with the exception of Flexible Spending Accounts (Health and Dependent Care) and Health Savings Accounts. I further understand Healthcare and Dependent Care Account elections do not roll over and must be elected each Plan Year.

Employee Signature: _____ **Date:** _____