OLIN PLUMBING, INC.

Benefit Enrollment/Change Form

Medical, Dental & Vision Insurance

EMPLOYEE INFORMATION		**Effective: 1/1/2019**	
Name (Last, First, MI)	Date of Birth	Hire Date	Annual Salary
Mailing Address (Street, City, State, Zip)	Phone	Social Security #	Gender ☐Male ☐Female

☒ Open Enrollment ☐ New Hire Enrollment ☐ Coverage Change

Humana Medical Plans	**Humana Dental Plans**	**Humana Vision Plan**
☐ HMO $1500 COPAY ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family *[Employee, Spouse, Child(ren)* ☐ **DECLINE MEDICAL COVERAGE**	☐ Basic Plan ☐ Low Plan ☐ High Plan ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family *[Employee, Spouse, Child(ren)]* ☐ **DECLINE DENTAL COVERAGE**	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family *[Employee, Spouse, Child(ren)* ☐ **DECLINE VISION COVERAGE**

Dependent	**Name (Last, First, MI)**	**Date of Birth**	**SS#**	**Gender M / F**	**Select Coverage**
Spouse	_____				☐ Medical ☐ Dental ☐ Vision
Child	_____				☐ Medical ☐ Dental ☐ Vision
Child	_____				☐ Medical ☐ Dental ☐ Vision
Child	_____				☐ Medical ☐ Dental ☐ Vision
Child	_____				☐ Medical ☐ Dental ☐ Vision

Pre-Tax Premium Plan for Medical, Dental & Vision Plans

☐ **YES**, I accept the opportunity to enroll in the Pre-Tax Premium Plan offered to me here. I hereby authorize my employer to deduct from my salary each pay period the amount necessary to make my contributions toward payment of premiums for the offered Medical, Dental, & Vision plans. I understand that the tax implications for the pre-tax program are regulated by the IRS. I hold my employer harmless if any damages or losses occur to me, including penalty and interest assessment by the IRS. _____ **(Initials)**

☐ **NO**, I decline the opportunity to enroll in the offered Pre-Tax Premium Plan. I understand that I may enroll later at the time of annual enrollment.

EMPLOYEE AUTHORIZATION & SIGNATURE

I certify that all information supplied in this form is true to the best of my knowledge. I understand that all benefits for me and my eligible dependents will be provided in accordance with the terms of the plan(s) in which I have enrolled. I agree to abide by the terms and conditions provided in the plan(s). I authorize my employer to reduce my salary in an amount necessary to pay for my benefit elections.

I understand that if I do not elect benefits at the time of my initial eligibility, I will not be permitted to enroll or make authorized changes unless a "Family Status Change" occurs or until the next Annual Enrollment period. Furthermore, I understand if I experience a "Family Status Change" and would like to enroll or make authorized changes to my benefit plans, I must notify OLIN PLUMBING and submit evidentiary documentation within 30 days of my family status change. If these procedures are not followed, I will not be permitted to enroll or to make changes until the next Annual Enrollment period.

Employee Signature: _____ Date: _____