Andover Corporation

OPEN ENROLLMENT FORM 2024

EMPLOYEE INFORMATION **Effective Date: 1 /1 / 2024** **Date of Hire: ___ / ___ / ___**

Check Appropriate Box:

☒ **Open Enrollment** ☐ **Add Dependent** ☐ **Drop Dependent** ☐ **Rehire** ☐ **New Hire**

☐ **Life Status Change** Reason _____ (Attach Support Documents)

_____ Employee Last Name

_____ Employee First Name

_____ M.I.

☐ Male ☐ Single ☐ Divorced

☐ Female ☐ Married ☐ Widowed

___ ___ Social Security Number

☐ Salaried ☐ Hourly

_____ Hours worked per week

Date of Birth: ___ / ___ / ___

_____ Address (Street and Apt #)

_____ City

_____ State

_____ Zip Code

_____ Email Address

_____ Area Code/Home Phone No.

_____ Job Title/Occupation

_____ Annual Salary or Hourly Rate of Pay

☐ By checking this box and signing below, I am stating that I do NOT want to change ANY of my current elections or covered dependents for the 2024 plan year. Please continue my 2023 enrollments into the 2024 plan year.

_____ SIGNATURE / DATE

MEDICAL	**Anthem BCBS of OH** Policy L01680

☐ **Add** ☐ **Change** ☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___

I WISH TO INDICATE THE FOLLOWING ELECTIONS: Check the appropriate coverage level.

PPO | HRA **$5,000/ | $10,000 Deductible;** **$7,350 | $14,700 Out of pocket maximum**		**Per Pay Deduction**
	Employee Only	☐ $53.35
	Employee + Spouse	☐ $117.27
	Employee + Child(ren)	☐ $90.06
	Employee + Family	☐ $164.70

DENTAL	**Delta** Policy 14222-1000/2000

☐ **Add** ☐ **Change** ☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___

I WISH TO INDICATE THE FOLLOWING ELECTIONS: Check the appropriate coverage level.

PPO **$100/$300 deductible** **$2,000 annual max**		**Per Pay Deductions**
	Employee Only	☐ $3.59
	Employee + 1 Dependent	☐ $6.55
	Employee + 2 or more Dependents	☐ $11.05

Dental Disclaimer: If you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Delta Dental may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

VISION	**Guardian VSP** Policy 400455684

☐ **Add** ☐ **Change** ☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___

I WISH TO INDICATE THE FOLLOWING ELECTIONS: Check the appropriate coverage level.

PPO - VSP **$10 Exam; Frequencies: Exam - every 12 months; Lenses - every 12 months; Frames - every 24 months**		**Per Pay Deductions**
	Employee Only	☐ $0.53
	Employee + 1 Dependent	☐ $0.90
	Employee + 2 or more Dependents	☐ $1.58

LIFE AND AD&D INSURANCE	**Guardian** Policy 00455684

Employees automatically enrolled. 100% paid by your employer. This benefit is payable to your designated beneficiary(ies) if you pass away.

BENEFICIARY DESIGNATION FOR BASIC LIFE INSURANCE

Primary Beneficiary	Social Security Number	Relationship	Share (Amount must equal 100%)
Secondary Beneficiary			

VOLUNTARY LIFE AND AD&D

Guardian Policy 00455684

Employee chooses to pay if enrolling. **Rates are Age-Banded**. Please refer to the Guardian benefit summaries for details and input rate in the "Total" Box below.

EMPLOYEE	☐ **Add** ☐ **Change**	☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___	**TOTAL:**	**COVERAGE AMOUNT:**
SPOUSE	☐ **Add** ☐ **Change**	☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___	**TOTAL:**	**COVERAGE AMOUNT:**
CHILD(REN)	☐ **Add** ☐ **Change**	☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___	**TOTAL:**	**COVERAGE AMOUNT:**

IF YOU ELECTED TO WAIVE OPTIONAL LIFE AT THE TIME OF ELIGIBILITY, YOU WILL BE SUBJECT TO EVIDENCE OF INSURABILITY AND GUARDIAN RESERVES THE RIGHT TO DECLINE YOUR COVERAGE REQUEST.

BENEFICIARY DESIGNATION FOR VOLUNTARY LIFE AND AD&D INSURANCE

Primary Beneficiary	Social Security Number	Relationship	Share (Amount must equal 100%)
Secondary Beneficiary			

VOLUNTARY SHORT TERM DISABILITY

Guardian Policy 00455684

Employee chooses to pay if enrolling. Rates are Age-Banded. Please refer to the Guardian benefit summaries for details and input rate in the "Total" Box below. This benefit provides 60% of your predisability earnings up to $1,500 per week. Benefits begin on day 8 upon claims approval.

EMPLOYEE	☐ **Add** ☐ **Change**	☐ **Decline** ☐ **Cancel** effective date ___ / ___ / ___	**TOTAL:**	**COVERAGE AMOUNT:**

VOLUNTARY LONG TERM DISABILITY

Guardian Policy 00455684

Employee chooses to pay if enrolling. Rates are Age-Banded. Please refer to the Guardian benefit summaries for details and input rate in the "Total" Box below. This benefit provides 66 2/3% of your predisability earnings up to a monthly max of $7,000. Benefit begin on day 90 upon claims approval.

EMPLOYEE	◯ **Add** ◯ **Change**	◯ **Decline** ◯ **Cancel** effective date ___ / ___ / ___	**TOTAL:**	**COVERAGE AMOUNT:**

IF YOU ELECTED TO WAIVE VOLUNTARY STD AND/OR LTD AT THE TIME OF INITIAL ELIGIBILITY, YOU WILL BE SUBJECT TO EVIDENCE OF INSURABILITY AND GUARDIAN RESERVES THE RIGHT TO DECLINE YOUR COVERAGE.

DEPENDENTS

Complete information below for eligible spouse, domestic partner and/or dependents to be covered on medical and dental. Providers can be found online at www.anthem.com and www.guardianlife.com. Birth Certificates and/or Marriage Licenses may be required and should be submitted to HR with this form where applicable. (If more space is needed please add additional dependents on a separate piece of paper)

Add/Drop	Full Name (First, Last, Middle Initial)	Social Security Number	Birth Date (MM/DD/YYYY)	Gender	Medical	Dental	Vision	Full Time Student
☐ A ☐ D	Spouse: :		___ / ___ / ___	☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
☐ A ☐ D	Dep:		___ / ___ / ___	☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
☐ A ☐ D	Dep:		___ / ___ / ___	☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
☐ A ☐ D	Dep:		___ / ___ / ___	☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

IMPORTANT TAX NOTICE

Your share of premium contributions for medical and dental coverage will be deducted from your paycheck on a pre-tax basis. This means that, starting with the first paycheck from which employee contributions are deducted, your taxable income will be reduced. The reduction will equal the amount of your contributions, including contributions for spouse and dependent coverage, but excluding contributions for domestic partner coverage (which generally must be paid on a post-tax basis under federal law. As a result, your federal and state income taxes, as well as Social Security and Medicare taxes, will be reduced and your net pay will be greater than it would be if your contributions were made on a post-tax basis. (Note: This may cause a slight reduction in your future monthly Social Security retirement benefits.

TRUTH & KNOWLEDGE DISCLAIMER

I attest that the information provided above is true and correct to the best of my knowledge.

FRAUD STATEMENT

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

ACKNOWLEDGEMENT

I have read the above notice describing my payroll deduction options for benefit coverage contributions. I understand that my contributions are made on a pre-tax basis and I will not be able to change my elections or discontinue coverage at any time during the plan year except in the case of a family status change consistent with IRS regulations.

In the event of any discrepancy between this enrollment form and the underlying benefit plan documents, the terms of the plan documents control. Complete benefit coverage and enrollment information is available in the certificate of insurance booklets, summary plan descriptions and open enrollment guide. These can be obtained through Human Resources.

Print Name ______________________________ Signature ______________________________ Date ____________