ASKAR BRANDS

ENROLLMENT/WAIVER FORM

Effective: August 1, 2021 – July 31, 2022

STEP 1: COMPLETE YOUR PERSONAL AND DEPENDENT INFORMATION

All information must be completed to process form. Incomplete forms will be returned and not processed

EMPLOYEE INFORMATION

Last name	First name	Middle initial	Social Security number - -
Street address	City	State	ZIP code
County	Phone	Gender	Birth date (month/day/year) / /
Email address			Age
			Marital status ☐ Divorced ☐ Widowed ☐ Single ☐ Married

EMPLOYMENT INFORMATION (To be completed by employer)

Original date of hire	For re-hire employee – Date of re-hire / /	Eligibility date / /	Effective date / /
Location	Salary/Hourly Earnings	Class	Occupation

Please check all applicable boxes	Reason ☐ New hire	☐ Re-hire	☐ Open enrollment	☐ Change of employment status	☐ Birth
		☐ Marriage	☐ Loss of coverage	☐ Other	

**If you have more than four (4) dependents complete an additional form and include it with this form.*
***Check the applicable coverage box to confirm enrollment for your spouse and/or child(ren).*

DEPENDENT INFORMATION (Your spouse and eligible children you wish to enroll)

SPOUSE ☐ Medical ☐ Dental ☐ Vision ☐ Life	Dependent last name	First name	Middle initial	
	Social Security number - -	Birth date (month/day/year) / /	Age	Gender
CHILD 1 ☐ Medical ☐ Dental ☐ Vision ☐ Life	Dependent last name	First name	Middle initial	
	Social Security number - -	Birth date (month/day/year) / /	Age	Gender
CHILD 2 ☐ Medical ☐ Dental ☐ Vision ☐ Life	Dependent last name	First name	Middle initial	
	Social Security number - -	Birth date (month/day/year) / /	Age	Gender
CHILD 3 ☐ Medical ☐ Dental ☐ Vision ☐ Life	Dependent last name	First name	Middle initial	
	Social Security number - -	Birth date (month/day/year) / /	Age	Gender

ASKAR BRANDS

ENROLLMENT/WAIVER FORM

Effective: August 1, 2021 – July 31, 2022

STEP 2: REVIEW YOUR COMPANY PAID BENEFITS

You must complete the beneficiary section.

EMPLOYER PAID LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT

PRINCIPAL #1102990

Flat $20,000 Benefit Amount

Benefit Reduction Schedule:
35% of the original amount at age 65 / 50% of the original amount at age 70

BENEFICIARY INFORMATION FOR LIFE INSURANCE/AD&D (Primary beneficiary required): All Fields Required

Primary: Last Name	First Name	MI	Relationship	Social Security Number		%	Gender
Street Address			**City**	**State**	**Zip**	**DOB**	**Phone Number**
Primary or Contingent: Last Name	**First Name**	**MI**	**Relationship**	**Social Security Number**		**%**	**Gender**
Street Address			**City**	**State**	**Zip**	**DOB**	**Phone Number**

NOTE: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper. Beneficiary designation for Life Insurance may be changed at any time. The percentage for either the Primary or the Contingent Beneficiary category must equal 100%.

EMPLOYER PAID SHORT TERM DISABILITY

PRINCIPAL #1102990

60% of base weekly earnings to a maximum of **$1,000 per week**
Benefits begin on the 1st day for accident and 8th day for sickness
Benefits payable for up to 26 weeks

Confirm your coverage selections and enter your total cost per pay.

$0.00 (company paid benefits)

IF YOU ARE WAIVING ALL BEENFITS, YOU CAN MOVE ON TO THE FINAL STEP OF YOUR ENROLLMENT/WAIVER FORM ON PAGE 6

ASKAR BRANDS

ENROLLMENT/WAIVER FORM

Effective: August 1, 2021 – July 31, 2022

STEP 3: CHOOSE YOUR BENEFITS: Pre-Tax

Deductions out of your paycheck for the benefits below will be on a Pre-Tax, Semi-Monthly basis.

MEDICAL/RX

☐ Check this box to WAIVE coverage OR select your plan and coverage level below.

BLUE CROSS BLUE SHIELD OF MICHIGAN #007030947

STEP 1 – Select your Plan

☐ **GOLD – PPO 1500** (0000)	☐ **SILVER – PPO 4000** (0001)	☐ **BRONZE – PPO HSA 6900** (TBD)

STEP 2 – Confirm your Coverage & Cost

****See the age rate tables illustrated on the next page to confirm the cost per pay****

Check the Box for each Person Enrolling in Medical/Rx Coverage	Enter the Age As of 8/1/2021	Enter the Cost Per Pay
☐ Employee		$
☐ Spouse		$
☐ Child 1		$
☐ Child 2		$
☐ Child 3		$
Add your employee, spouse and/or child(ren) rates to get your total →		$

**If you have more than four (4) dependents complete an additional form and include it with this form.*
***The dependent cap for family contracts is three, meaning family contracts will be charged for the subscriber/employee and spouse, all dependents age 21 and older, and the three oldest dependents under the age of 21.*

HEALTH SAVINGS ACCOUNT (HSA)

☐ Check this box to WAIVE HSA contributions or make your elections below

HEALTH EQUITY

2021 IRS MAXIMUM	Select HSA Account Type	Enter your Annual Election	Enter your Per Pay Amount / 24
$3,600	☐ Single	$	$
$7,200	☐ Two Person/Family	$	$

**If you are age 55 or older you can contribute an additional $1,000 per year to your HSA in addition to the maximum contributions noted above.*

DENTAL

☐ Check this box to WAIVE coverage OR select your coverage below.

MMA/METLIFE #5050001-5220

Plan	PPO 100/80/50/50
Single	☐ $6.91
Two Person	☐ $13.78
Family	☐ $25.14

VISION

☐ Check this box to WAIVE coverage OR select your coverage below.

MMA METLIFE #5050001-5220

Plan	12/12/12
Single	☐ $3.38
EE & Spouse	☐ $6.78
EE & Child(ren)	☐ $5.74
Family	☐ $9.46

Confirm your coverage selections and enter your total cost per pay. $

ASKAR BRANDS

ENROLLMENT/WAIVER FORM

Effective: August 1, 2021 – July 31, 2022

MEDICAL/RX PLAN AGE RATES

Check the box for your plan selection and find your employee, spouse and/or children's age as of August 1, 2021

☐ GOLD – PPO 1500 Semi-Monthly Age Rates

Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate
0-14	$62.30	25	$81.77	36	$100.17	47	$127.29	58	$207.51
15	$67.84	26	$83.40	37	$100.82	48	$133.16	59	$211.99
16	$69.96	27	$85.35	38	$101.48	49	$138.94	60	$221.03
17	$72.08	28	$88.53	39	$102.78	50	$145.45	61	$228.85
18	$74.36	29	$91.13	40	$104.08	51	$151.89	62	$233.98
19	$76.64	30	$92.44	41	$106.04	52	$158.97	63	$240.41
20	$79.00	31	$94.39	42	$107.91	53	$166.14	64	$244.32
21	$81.44	32	$96.34	43	$110.52	54	$173.88	65+	$244.32
22	$81.44	33	$97.57	44	$113.77	55	$181.61	Comp	$208.81
23	$81.44	34	$98.87	45	$117.60	56	$190.00		
24	$81.44	35	$99.52	46	$122.16	57	$198.47		

☐ SILVER – PPO 4000 Semi-Monthly Age Rates

Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate
0-14	$50.15	25	$65.81	36	$80.62	47	$102.45	58	$167.02
15	$54.60	26	$67.12	37	$81.15	48	$107.17	59	$170.62
16	$56.31	27	$68.70	38	$81.67	49	$111.83	60	$177.90
17	$58.01	28	$71.25	39	$82.72	50	$117.07	61	$184.19
18	$59.85	29	$73.35	40	$83.77	51	$122.25	62	$188.32
19	$61.68	30	$74.40	41	$85.34	52	$127.95	63	$193.50
20	$63.58	31	$75.97	42	$86.85	53	$133.72	64	$196.64
21	$65.55	32	$77.54	43	$88.95	54	$139.95	65+	$196.64
22	$65.55	33	$78.53	44	$91.57	55	$146.17	Comp	$208.81
23	$65.55	34	$79.58	45	$94.65	56	$152.92		
24	$65.55	35	$80.10	46	$98.32	57	$159.74		

☐ BRONZE – PPO HSA 6900 Semi-Monthly Age Rates

Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate	Age Tier	Member Rate
0-14	$42.93	25	$56.34	36	$69.02	47	$87.71	58	$142.98
15	$46.75	26	$57.46	37	$69.47	48	$91.75	59	$146.07
16	$48.20	27	$58.81	38	$69.92	49	$95.73	60	$152.30
17	$49.66	28	$61.00	39	$70.82	50	$100.22	61	$157.68
18	$51.23	29	$62.79	40	$71.72	51	$104.66	62	$161.22
19	$52.81	30	$63.69	41	$73.06	52	$109.54	63	$165.65
20	$54.43	31	$65.04	42	$74.35	53	$114.48	64	$168.35
21	$56.12	32	$66.39	43	$76.15	54	$119.81	65+	$168.35
22	$56.12	33	$67.23	44	$78.39	55	$125.14	Comp	$208.81
23	$56.12	34	$68.12	45	$81.03	56	$130.92		
24	$56.12	35	$68.57	46	$84.17	57	$136.75		

ASKAR BRANDS

ENROLLMENT/WAIVER FORM

Effective: August 1, 2021 – July 31, 2022

STEP 4: CHOOSE YOUR BENEFITS: Post-Tax

Deductions out of your paycheck for the benefits below will be on a Post-Tax, Semi-Monthly basis.

OPTOINAL LIFE ☐ Check this box to WAIVE coverage OR select your plan and coverage level below.

UNUM #0428470

STEP 1 – Select your Plan

Plan Options	Coverage Maximum	Increments of	Guarantee Issue Amount
Employee	The lesser of: 5x annual earnings; or $500,000*	$10,000	$40,000*
Spouse	The lesser of: 100% of your amount; or $500,000*	$5,000	$15,000*
Child(ren)	The lesser of: 100% of your amount; or $10,000	$2,000	$10,000

**Benefit Reduction Schedule: 35% of the original amount at age 70 / 50% of the original amount at age 75*

STEP 2 – Confirm your Coverage & Cost

****See the age rate tables below to complete and confirm the cost per pay****

Check the Box for each member enrolling in Optional Life Coverage	Enter the Coverage Amount	Complete the Cost Calculation	Enter the Cost Per Pay
EXAMPLE – Age 45	*$50,000*	*0.000101*	*$5.05*
☐ Employee		Multiply by Age Factor	**$**
☐ Spouse		Multiply by Age Factor	**$**
☐ Child(ren)*		Multiply by 0.000185	**$**

**One premium amount covers al eligible children from 6 months up to age 19 or 26 if full time student*

Add your employee, spouse and/or child rates to get your total → $

Age	Employee Non-Tobacco	Employee Tobacco	Spouse
15 - 24	0.000023	0.000035	0.000032
25 - 29	0.000027	0.000040	0.000036
30 - 34	0.000033	0.000049	0.000046
35 - 39	0.000046	0.000074	0.000066
40 - 44	0.000063	0.000111	0.000095
45 - 49	0.000101	0.000176	0.000148
50 - 54	0.000154	0.000297	0.000230
55 - 59	0.000251	0.000418	0.000353
60 - 64	0.000402	0.000625	0.000604
65 - 69	0.000705	0.001045	0.001031
70 - 74	0.001272	0.001837	0.001837
75 +	0.002574	0.003322	0.003679

Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Optional Life, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, if enrolled when first eligible, you are able to increase elections up to the GI amount without proof of good heath. Any amounts elected over the GI will require EOI. In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is newly requested after initially eligible.

Please visit https://securehealth.unum.com when you need to complete an EOI application.

Confirm your coverage selections and enter your total cost per pay. **$**

ASKAR BRANDS

ENROLLMENT/WAIVER FORM

Effective: August 1, 2021 – July 31, 2022

FINAL STEP: CONFIRM YOUR BENEFITS

This must be turned in to the HR Department immediately after you sign and date the enrollment/waiver form.

MEDICAL/RX, DENTAL, VISION & OPTIONAL LIFE

WAIVE ALL BENEFITS

This section is **ONLY** required for all eligible employees who are not enrolling with **Askar Brands** benefits at the time of initial enrollment or the annual open enrollment period.

I understand that I am eligible for Medical/Rx, Dental, Vision and Optional Life coverage through my employer. I waive the right to enroll in these benefits as offered to me by my employer for the following reason (please check one):

☐ I have other coverage through my spouse or other family member
☐ I have other coverage through Medicare or a pension plan
☐ I have other coverage through another source that is not employer-sponsored or employer paid
☐ I have no other coverage but choose not to enroll in my employer's plan
☐ I am waiving for other employer-paid coverage

NOTE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you wish to add a new dependent or terminate coverage as a result of a change in family status, such as marriage, birth, adoption, or placement for adoption, you may be able to do so, provided that you request enrollment/termination within 30 days after the qualified status change. We will require proof of this other coverage. If you do not supply proof, you will be denied these special enrollment rights.

MARKETPLACE NOITCE

Enrollment in one of the group-sponsored medical plans will satisfy the individual mandate under the ACA. The offered coverage also meets minimum value and affordability standards. This means if you were to purchase coverage through the Michigan Marketplace (public exchange), you would not be entitled to any subsidies, even if you meet other eligibility requirements. If you have any questions about the Affordable Care Act or the Michigan Marketplace, please call 1.800.318.2596 or visit www.healthcare.gov.

SIGNATURE/AUTHORIZATION

While every effort has been made to assure accuracy in the plan definitions on this form, I understand that this is strictly an election form. The contracts that my employer has signed with the insurance carriers and plan documents will be binding. I understand that this election may not be changed during the plan year unless I have a qualified status change and that unused allocations, if any, by law, will be forfeited according to the plan documents. I authorize my employer to reduce my wages by the amounts required (if needed) to pay for the Flexible Benefit Options I have elected. My signature below acknowledges my elections on pages 1-6.

Print Name: _____

Signature: _____ Date: _____