



Benefit Menu Election/Waiver Sheet

**Company Name:** House of Hope **Benefits Plan Year:** 1/1/2022 to 12/31/2022

**Employee Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Your Beneficiary Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- |
| **Benefit Type (and Carrier)** | **Carrier** | **Pre or Post Tax** | **Plan Description** | **Paid by:** | **Choose Coverage Type**  (circle one) | **Circle One** |
| Health Insurance  HMO  HRA benefits | Network Health  EBC Flex | Pre | **HRA Benefits**: ZERO-dollar deductible. You pay 35% of all bills until you have paid $2450/Single, $4900/family.  Max out of pocket $2450 single/$4900 family  Claims are automatically sent to EBC by Network Health.  **PLAN Benefits**: $7000 single/$14,000 family deductible, then 100% coinsurance. If you have other family members on the plan, each family member must meet their own individual deductible until the total family deductible is met. Out of pocket maximum $7000 Single/$14,000 family.  Office visit & Prescription to deductible then 100% Benefits in network only. See Network Health Benefit Sheet for complete plan details  [*www.ebcflex.com*](about:blank)[*www.networkhealth.com*](about:blank) | Company and Employee | Employee EE & Spouse  EE & Kids Family | **Enroll**  **Waive** |
| Dental  Passive Plan | Delta Dental | Pre | Provides Preventative coverage at 100%, cleaning every 6 months with coverage on x-rays/fluoride treatments. Pays 80% of minor and 50% on major services up to $1,000 a year per person. $1,500 lifetime ortho coverage (up to 50%)  [*www.deltadentalwi.com*](about:blank) | Company and Employee | Employee EE & Spouse  EE & Kids Family | **Enroll**  **Waive** |
| Vision  Full Plan | Delta  Vision | Pre | You pay $10 copay for standard plastic lenses, $130 every 2 years for frames. $120 every year for contacts. You pay $10 to see optometrist 1x/year. Plus, up to 20-40% discounts.  [www.deltadentalwi.com](about:blank) | Company | Employee EE & Spouse  EE & Kids Family | **Enroll**  **Waive** |
| Basic Life Insurance | Hartford | Post | $25,000 benefits and matching accidental death benefit  .  [www.hartford.com](about:blank) | Company | Automatic Enrollment | **Enroll**  **Waive** |
| Dependent Life Insurance | Hartford | Post | Dependent Life: Spouses: $25,000 life benefit Children: $10,000 per child – cost is $7.74/month per family unit  Life benefits reduce at age 65 and beyond, see certificate for details.  [www.hartford.com](about:blank) | Employee | Employee EE & Spouse  EE & Kids Family | Employee only |
| Short Term Disability | Hartford | Post | Pays up to 60% of your gross pre-disability earnings up to a maximum of $750/week. Pays as early as day 1 for injuries and after 8 days for sickness for up to 13 weeks.  [www.hartford.com](about:blank) | Company | Automatic Enrollment | Employee only |
| Long Term Disability | Hartford | Post | Pays up to 60% of your gross pre-disability earnings up to a maximum of $3000/month. Benefits begin after Short Term coverage ends or 90 days.  [www.hartford.com](about:blank) | Company | Automatic Enrollment | Employee only |

I consent that House of Hope can enroll/waive me in the following coverages and withhold premiums from my paycheck for the coverages I elect. If I don’t elect in time,

I will not be enrolled in benefits. I understand that if I do not check to enroll that I waive coverage and cannot re-elect coverage until the next open enrollment or a qualifying event.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Internal Form only.** You still must actually fill out the enrollment application to enroll. Does not guarantee coverage.