2023-2024 OPEN ENROLLMENT BENEFIT ELECTION FORM

Please make your benefit elections on this form.
Upon completion, return to HR.

EMPLOYEE INFORMATION

Name_____ **Date of Hire** _____
Address_____**City**_____**State**_____**Zip**_____
Phone_____**Email**_____
DOB_____ **SS #**_____ **Male Female Tobacco User: Yes No**
Occupation_____**Salary $**_____**/year $**_____**/hour**

DEPENDENT INFORMATION – Please complete for all dependents you wish to cover

Spouse	Last Name	Sex	Tobacco?	DOB	SS#
Child(ren) First Name	**Last Name**	**Sex**	**FT Student**	**DOB**	**SS#**
			Yes No		
			Yes No		
			Yes No		
			Yes No		

MEDICAL COVERAGE – UHC – Please elect plan and coverage tier

Plan 1 – CAZH Rx Plan UE0Y	
$3,000 Deductible 100/50%	
Tier	**Weekly Pay Period Deduction**
Employee Only	$ 41.00
Employee/Spouse	$ 275.00
Employee/Children	$ 195.00
Employee/Family	$ 395.00

I elect to ENROLL in Plan 1 _____

I elect to COVER EE Only_____ **EE/Spouse**_____ **EE/Child(ren)**_____ **EE/Family**_____

I elect to WAIVE Medical coverage_____ **Reason for waiving**_____

Employee Name_____ Asa Healthcare Solutions

VOLUNTARY DENTAL – GUARDIAN – Please elect coverage tier

Network Access Plan (NAP)		
Coverage Tier	Pay Period Deduction	Select Tier
Employee Only	$ 7.19	
Employee/Spouse	$ 14.60	
Employee/Children	$ 17.49	
Employee/Family	$ 26.48	

I elect to ENROLL in the Dental Network Access Plan (NAP) _____

I elect to COVER:

EE Only_____ EE/Spouse_____
EE/Child(ren)_____ EE/Family_____

I elect to WAIVE Dental coverage_____

VOLUNTARY VISION – GUARDIAN – Please elect coverage tier

Coverage Tier	Pay Period Deduction	Select Tier
Employee Only	$ 1.54	
Employee/Spouse	$ 2.91	
Employee/Children	$ 2.97	
Employee/Family	$ 4.70	

I elect to ENROLL in the Vision plan_____

I elect to COVER EE Only_____ EE/Spouse_____

EE/Child(ren)_____ EE/Family_____

I elect to WAIVE Vision coverage_____

VOLUNTARY LIFE/AD&D – GUARDIAN – Use the chart provided to determine your bi-weekly deduction and enter below

Maximum Employee Benefit $500,000 Maximum Spouse Benefit $250,000
Guarantee Issue $100,000 Guarantee Issue $25,000

During this initial enrollment period you can elect up to the guarantee issue amount without having to complete an Evidence of Insurability form (EOI). If you elect an amount over the guarantee issue amount, you will be asked to complete an EOI form.

I elect to PURCHASE $_____Employee Life/AD&D $_____ Weekly Deduction
I elect to PURCHASE $_____Spouse Life/AD&D $_____ Weekly Deduction
I elect to PURCHASE $10,000 Child(ren) Life/AD&D _____ $_____ Weekly Deduction
$_____ Total Deductions

I elect to WAIVE Voluntary Life/AD&D coverage_____

Employee Name_____ Asa Healthcare Solutions

GUARDIAN – Accident Plan

PLAN 1 – Standard Plan Coverage Tier	Weekly Deduction	Select Tier
Employee Only	$ 2.89	
Employee/Spouse	$ 4.46	
Employee/Child(ren)	$ 3.35	
Family	$ 4.92	
PLAN 2 – Expanded Plan Coverage Tier	**Weekly Deduction**	**Select Tier**
Employee Only	$ 4.33	
Employee/Spouse	$ 6.70	
Employee/Child(ren)	$ 5.48	
Family	$ 7.85	

I would like to ENROLL in PLAN 1_____ Plan 2_____

I would like to COVER
EE Only_____ EE/Spouse_____
EE/Child(ren)_____ EE/Family_____

I elect to WAIVE the Accident plan_____

GUARDIAN – Use the rates below to determine your CRITICAL ILLNESS Deductions

Critical Illness Insurance – Weekly Premium

Employee							
Benefit Amounts		**<30**	**30-39**	**40-49**	**50-59**	**60-64**	**65+**
Non-Tobacco	$10,000	$2.72	$2.82	$4.08	$6.58	$14.01	$15.44
Tobacco	$10,000	$3.67	$3.74	$6.16	$11.93	$25.36	$27.78
Spouse							
Benefit Amounts		**<30**	**30-39**	**40-49**	**50-59**	**60-64**	**65+**
Non-Tobacco	$10,000	$1.73	$2.15	$3.42	$5.28	$12.55	$13.75
Tobacco	$10,000	$2.15	$2.28	$5.22	$11.17	$24.07	$26.19
Underwriting							
Guarantee Issue	Employee	$10,000					
	Spouse	$10,000					
	Child	All amounts are guaranteed issue. Cost is included with employee election at 25% of employee face amount.					
Pre-Existing Condition Limitation	12-month look back period, 12-month exclusion period, continuity of coverage						

I elect to PURCHASE $10,000 _____

I elect to COVER Employee _____ Employee/Spouse_____
I elect to WAIVE the Critical Illness plan_____

Please note that the child cost is included in the Employee Only cost. If you list children on your form and you elect Critical Illness coverage, we will enroll them.

Employee Name_____ **Asa Healthcare Solutions**

GUARDIAN – CANCER Plan

Coverage Tier	Weekly Deduction	Select Tier
Employee	$ 3.46	
Employee + Spouse	$ 6.69	
Employee + Child(ren)	$ 3.92	
Family	$ 7.15	

I elect to ENROLL and COVER:

EE Only_____ EE/Spouse_____

EE/Child(ren)_____ EE/Family_____

I elect to WAIVE the Cancer plan _____

GUARDIAN – Beneficiary Form

Please complete the Guardian beneficiary form on the next page.

By my signature below I confirm I elect to enroll in the benefit plans as indicated on this form. I understand that my elections cannot be changed until the next open enrollment period for a June 1, 2024 effective date unless I experience a change in status or a qualifying event.

_____ _____

Signature Date

GUARDIAN®

□ Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

□ Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

□ Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Beneficiary Designation/ Change Form

PLEASE TYPE or PRINT CLEARLY. *(The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)*

EMPLOYER/PLANHOLDER NAME:	GROUP NUMBER
EMPLOYEE NAME (LAST, FIRST, M.)	SOCIAL SECURITY #
EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)	

I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan.
(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)

BENEFICIARY INFORMATION: *(Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter.*

Primary: 1) _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (Social Security #) ____ %
_____ (Address)

2) _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (Social Security #) ____ %
_____ (Address)

Contingent: 1) _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (Social Security #) ____ %
_____ (Address)

2) _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (Social Security #) ____ %
_____ (Address)

If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan.

SIGNATURE OF INSURED	SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY)	DATE

ALL SIGNATURES MUST BE IN INK

CHANGE IN BENEFICIARY'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE

CHANGE IN INSURED'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE
SIGNATURE OF INSURED			DATE

ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM

THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY.

This is to certify that the following changes have been recorded in connection with the insurance for the above named insured.

☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee

Recorded by _____ Date _____

FORWARD FORM TO THE PLANHOLDER OR GUARDIAN LIFE INSURANCE FOR RECORDING