Reason for Request:
☐ 1. New Hire
☐ 2. Open Enrollment
☐ 3. Change

ATERRA DESIGNS

Benefits Enrollment Form (2022)

Employee Information — Reason 1, 2, 3

Employee Name: _____ ☐ M ☐ F

Social Security #: _____ Date of Birth: _____ Marital Status: ☐ S ☐ M

Address: _____ City: _____ State: ____ Zip: _____

Annual Salary: $_____ Job Title: _____ Hours Per Week: _____

Dependent Information — Reason 1, 2, 3

Spouse Name: _____ Date of Birth _____ ☐ M ☐ F

SSN: _____ Medical ☐ Y ☐ N Dental ☐ Y ☐ N

#1Child Name: _____ Date of Birth _____ ☐ M ☐ F

SSN: _____ Medical ☐ Y ☐ N Dental ☐ Y ☐ N

#2Child Name: _____ Date of Birth _____ ☐ M ☐ F

SSN: _____ Medical ☐ Y ☐ N Dental ☐ Y ☐ N

#3Child Name: _____ Date of Birth _____ ☐ M ☐ F

SSN: _____ Medical ☐ Y ☐ N Dental ☐ Y ☐ N

#4Child Name: _____ Date of Birth _____ ☐ M ☐ F

SSN: _____ Medical ☐ Y ☐ N Dental ☐ Y ☐ N

#5Child Name: _____ Date of Birth _____ ☐ M ☐ F

SSN: _____ Medical ☐ Y ☐ N Dental ☐ Y ☐ N

Complete a separate sheet if you need to add additional dependents.

Employee contributions below are Per Pay-Period 24

Medical through UnitedHealthcare **Reason 1, 2, 3** (Please select ONE of the following options)

☐ I waive Medical coverage at this time (Refer to the Waiver Section)

☐ I elect the HSA $4,500 100% Plan w/ the Choice Plus Network (High Deductible Health Plan)

☐ EE Only $115.96 ☐ EE + SP $231.93 ☐ EE + Child(ren) $226.13 ☐ EE + Family $382.68

☐ I elect the PPO $1,500 80% Plan w/ the Choice Plus Network

☐ EE Only $111.30 ☐ EE + SP $222.60 ☐ EE + Child(ren) $217.04 ☐ EE + Family $367.29

Dental through Delta Dental of AZ **Reason 1, 2, 3** (Please select ONE of the following options)

☐ I waive Dental coverage at this time (Refer to the Waiver Section)

☐ I elect not to make any changes to my current Dental Elections at this time

☐ I elect the Delta Dental of AZ Dental Plan

☐ EE Only $6.34 ☐ EE + SP $13.24 ☐ EE + Child(ren) $15.28 ☐ EE + Family $25.16

Basic Life & AD&D Coverage through Principal $50,000 All Employees EMPLOYER PAID

****Please make sure your employer has the most current Beneficiary Data on File****

Short-Term Disability Coverage through Principal EMPLOYER PAID

This benefit will cover you up to 60% of your weekly income to a maximum of $1,000 per week.

Long-Term Disability Coverage through Principal EMPLOYER PAID

This benefit will cover you up to 60% of your monthly income to a maximum of $6,000 per month.

Waiver of Benefits If you are waiving Medical or Dental, a waiver reason is **REQUIRED.**

☐ Medical ☐ Dental

I acknowledge that my company has explained the available coverages to me. I have been given the opportunity to apply for the available coverage and have elected not to enroll myself (and/or dependents, if any). Further, I understand that if I am waiving coverage at this time due to other coverage, that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, or court order, I may enroll myself and my dependents, provided that I request enrollment within 30 days after the qualifying event. Covered by:

☐ Spouse's employer group plan ☐ Parents employer group plan ☐ Married Co-Workers ☐ TRICARE
☐ Medicare ☐ IHS (Indian Health Services) ☐ AHCCCS-Medicaid
☐ Individual Coverage w/carrier ☐ Individual Coverage w/Marketplace ☐ Does not want – no other coverage

Signature:_____ Date:_____

Cafeteria 125 Election **Reason 1, 2 & 3** **Disregard if you are waiving all benefits.**

I hereby elect for the IRS approved Flexible compensation premiums (medical, dental) to be deducted from my paycheck on a pre-tax basis. I understand my premiums may change and my deductions will change automatically.This election will continue as long as I remain employed with Aterra Designs or until the end of this plan year unless I notify the Company of desired change prior to the beginning of the Plan Year. I also understand these elections are irrevocable except for a qualified change in status and are not tax deductible.**Note**: I understand that I cannot make changes to my elections unless I have a qualified change in status and that change in status is completed within 30 days of the event date.

☐ **YES**, I agree to pay the employee contributions through a **BEFORE TAX** reduction of my salary.
I understand that:

- My Social Security benefits may be reduced by this election. This election to withhold this contribution on a before tax basis **precludes me from reporting this amount on my personal income tax return**

☐ **NO**, I do not elect to pay the employee contributions through a before tax reduction of my salary. Please withhold the selected amount **AFTER TAXES**.

Signature:_____ Date:_____

Qualifying Event - Change Request **Reason 3**

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This section needs to be completed when a qualifying event occurs during the plan year. Having a qualifying event allows you a special enrollment period where you can make changes to your current benefit elections as long as you request the change within 30 days from the Qualifying Event Date.

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☐ Marriage

☐ Divorce/ Legal separation

☐ Status change (full-time to part-time)

☐ Birth of a child

☐ Change in child's dependent status

☐ Death of a spouse, child, or other qualifying dependent

☐ Change in residence due to an employment transfer for you or your spouse

☐ Commencement or completion of adoption proceedings for a dependent child

☐ Change in spouse's benefits or employment status

Date of Qualifying Event:_____ Effective Date of Change:_____

Signature:_____ Date:_____

Employee HSA Payroll Contribution Form

(If you elected the HSA High Deductible Health Plan, completion of this form is required)

HSA Contribution Limits

Coverage Type	**2022 Maximum Allowed***
Single	$3,650
Family	$7,300

*Maximum Contributions includes all contributions made by yourself and others

Catch up contribution (age 55+) is $1,000

☐ I elect not to contribute to my HSA at this time

☐ I elect to contribute to my HSA $_____Per Pay Period

Print Name:_____

Employee Signature: _____ Date:_____