# Hill County

## Election Form

## Effective 10-1-20 / 9-30-21

| Personal Information | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name: *(nombre)* | | SSN: | | Date of Birth: *(fecha de naciemento)* | | | |
| City/State of Birth: | | Date of Hire: *(fecha de contratacion)* | | Salary: | | Gender: | |
| Email: *(correo electronico)* | | Job Title: *(puesto de trabajo)* | | DL # | | | |
| Address: *(direccion)* | Address: ____ *(direccion)* Apt. Number: ____ <br> City: ____ *(ciudad)* State: ____ *(estado)* Zip: ____ *(codigo postal)* Phone: ____ *(numero de telefono)* | | | | | | |

| Dependent Information *(Required if enrolling in NEW dependent coverage)* | | | | | | |
|---|---|---|---|---|---|---|
| | Name | Gender | Date of Birth | Height | Weight | Tobacco Use |
| Employee | | | | | | ☐ Yes / ☐ No |
| Spouse | | | | | | ☐ Yes / ☐ No |
| Child | | | | | | ☐ Yes / ☐ No |
| Child | | | | | | ☐ Yes / ☐ No |
| Child | | | | | | ☐ Yes / ☐ No |
| Child | | | | | | ☐ Yes / ☐ No |

| Accident – Guardian | Current Coverage: | | | |
|---|---|---|---|---|
| I want to: | ☐ Enroll NEW | ☐ Keep the Same | ☐ Waive coverage | ☐ Cancel coverage |
| Coverage: | ☐ Employee Only | ☐ Employee & Spouse | ☐ Employee & Child(ren) | ☐ Employee & Family |

| STD – Guardian | Current Coverage: | | | |
|---|---|---|---|---|
| I want to: | ☐ Enroll NEW | ☐ Keep the Same | ☐ Waive coverage | ☐ Cancel coverage |
| Coverage: | Benefit Period ____ | Benefit Amount ____ | Elimination Period ____ | |

| Cancer – Guardian | Current Coverage: | | | |
|---|---|---|---|---|
| I want to: | ☐ Enroll NEW | ☐ Keep the Same | ☐ Waive coverage | ☐ Cancel coverage |
| Coverage: | ☐ Employee Only | ☐ Employee & Spouse | ☐ Employee & Child(ren) | ☐ Employee & Family |

| Critical Illness – Guardian | Current Coverage: | | |
|---|---|---|---|
| I want to: | ☐ Enroll NEW | ☐ Keep the Same | ☐ Waive coverage | ☐ Cancel coverage |
| Change To: | ☐ Employee Benefit: __________/Rate: __________ ☐ Spouse Benefit: __________/Rate: __________<br>☐ Cover child(ren) at no additional cost | | | |
| | ☐ Drop my coverage ☐ Drop my spouse coverage ☐ Drop my child(ren) coverage | | | |

*Spouse is only eligible for same benefit as employee.* *** Children receive 25% of employee benefit at no cost.*

| Life Insurance – Texas Life | Current Coverage: | | | |
|---|---|---|---|---|
| I want to: | ☐ Enroll NEW | ☐ Keep the Same | ☐ Waive coverage | ☐ Cancel coverage |
| Coverage: | ☐ Employee Benefit: __________/Rate: __________ ☐ Spouse Benefit: __________/Rate: __________<br>☐ Child(ren) Benefit: __________/Rate: __________ | | | |
| | ☐ Drop my coverage ☐ Drop my spouse coverage ☐ Drop my child(ren) coverage | | | |

| Beneficiaries (Life and Accident)<br>*(beneficiaro)* | | | | |
|---|---|---|---|---|
| | Name<br>*(nombre)* | Relationship<br>*(relacion)* | Date of Birth<br>*(fecha de naciemento)* | Percentage |
| *Primary Beneficiary 1* | | | | |
| *Primary Beneficiary 2* | | | | |
| *Contingent Beneficiary 1* | | | | |
| *Contingent Beneficiary 2* | | | | |

## Cafeteria Plan: Authorization

| | | | | | |
|---|---|---|---|---|---|
| **Medical** | ☐ Pre-Tax | **Accident** | ☐ Pre-Tax | **Critical Illness** | ☐ After-Tax |
| **Dental** | ☐ Pre-Tax | **STD** | ☐ After-Tax | **Texas Life** | ☐ After-Tax |
| **Vision** | ☐ Pre-Tax | **Cancer** | ☐ Pre-Tax | | |

☐ I hereby AUTHORIZE my employer to make periodic salary reductions from my paycheck for the Election Period specified above in the amount equal to the premiums required for the coverage elected above. These deductions will be made continuous and in an amount equal to my required contribution for my elected coverage amount as prorated for each payroll period throughout the plan year. I authorize a corresponding change in the amount deducted from my salary without signing a new agreement. I understand that my elections, including coverage types, cannot be altered without a Qualified “Change in Family Status”.

☐ I elect to WAIVE all insurance benefits being offered to me. I cannot change or revoke this election at any time during the plan year, unless I have a change in status (such as marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse’s employment status from full-time to part-time or part-time to full-time, my spouse or I taking unpaid leave of absence, and such other events as the Plan Administrator determines will permit a change or revocation of an election. Prior to each Plan Year, I will be offered the opportunity to change my benefit election for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue to reject the benefits through this Plan.

By signing this form, I acknowledge the receipt and review of all necessary information pertaining to the coverages available to me by my Employer. I have been provided notices applicable to this program. I authorize my Employer to take any required deductions resulting from my elections.

Signature: ________________________________________ Date: ____________________

Printed Name: ______________________________________