WISCONSIN ILLINOIS SENIOR HOUSING INC.

2020 Enrollment Form

Employee Last Name	Employee First Name	MI

Marital Status: ☐ Single ☐ Married* ☐ Divorced ☐ Widowed

Home Phone	Work Phone	Date of Birth

Gender: ☐ Female ☐ Male

EMPLOYEE INSTRUCTIONS

1. Complete Personal Information.
2. Select your Benefits Options.
3. If you are electing coverage for dependents, please add your dependents information under the dependent section on PAGE 2.
4. Read the "Declaration Section" and sign the "Signature Section".
5. Return your completed enrollment form to your HR Administrator.

MEDICAL INSURANCE

$5000 Deductible $35/$70 Copays

Band	Wage			Employee Only ☐ Per Month	Employee Only ☐ Per Check	Employee + Spouse ☐ Per Month	Employee + Spouse ☐ Per Check	Employee + Child(ren) ☐ Per Month	Employee + Child(ren) ☐ Per Check	Employee + Family ☐ Per Month	Employee + Family ☐ Per Check
0	$7.25	-	$10.00	$92.93	$46.47	$581.50	$290.75	$393.60	$196.80	$1,145.23	$572.62
1	$10.01	-	$12.00	$128.31	$64.16	$616.88	$308.44	$428.98	$214.49	$1,180.61	$590.31
2	$12.01	-	$14.00	$153.94	$76.97	$642.51	$321.26	$454.61	$227.31	$1,206.24	$603.12
3	$14.01	-	$16.00	$179.58	$89.79	$668.15	$334.08	$480.25	$240.13	$1,231.88	$615.94
4	$16.01	-	$18.00	$205.22	$102.61	$693.79	$346.90	$505.89	$252.95	$1,257.52	$628.76
5	More than $18.01			$230.85	$115.43	$719.42	$359.71	$531.52	$265.76	$1,283.15	$641.58

☐ WAIVE MEDICAL INSURANCE **You MUST choose one option below:**

Please select reason: ☐ Individual Policy ☐ Medicare ☐ Spouse's insurance ☐ Other Employer's Plan ☐ State Plan ☐ Marketplace (Exchange) ☐ Parent's insurance ☐ No Plan

DENTAL INSURANCE

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Full Time	☐ $27.14 per month	☐ $63.23 per month	☐ $71.08 per month	☐ $107.55 per month
Part Time	☐ $39.14 per month	☐ $75.23 per month	☐ $95.08 per month	☐ $131.55 per month
	☐ WAIVE			

VISION INSURANCE

Employee Only	Employee + 1	Employee + 2 or more	WAIVE
☐ $5.63 per month	☐ $10.70 per month	☐ $15.72 per month	☐

FLEXIBLE SPENDING ACCOUNTS

Medical FSA Option (min = $100 and max = $2,700)

☐ I elect to waive / cancel

☐ I elect to contribute $ _____ per pay period X ____ pay periods = $ _____ annual election

*Pay periods remaining in 2020

Dependent Care FSA Option (Min = $100 and max = $5,000)

☐ I elect to waive / cancel

☐ I elect to contribute $ _____ per pay period X ____ pay periods = $ _____ annual election

IMPORTANT: FSA account elections can only be changed during the plan year if a Qualifying Event occurs.

COLONIAL LIFE VOLUNTARY OFFERINGS

Enrollment in Colonial Voluntary Short Term Disability, Accident, Hospital Confinement and Critical Illness w/Cancer insurance is only available through a Colonial Rep. If you are interested in enrolling, please contact your HR department for more information. If you'd like to cancel your coverage, please indicate below.

☐ I elect to waive / cancel Accident Insurance

☐ I elect to waive / cancel Hospital Confinement Insurance

☐ I elect to waive / cancel Critical Illness w/ Cancer Insurance

☐ I elect to waive / cancel Short Term Disabilty

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COMPANY PAID LIFE INSURANCE ~ For employees who are designated as Full Time, this benefit is paid for by Wisconsin Illinois Senior Housing through automatic enrollment. Please designate your beneficiaries below.

LIFE INSURANCE BENEFICIARY DESIGNATION

Name (Last, First)	Relationship	Date of Birth	SSN	%	Primary
Name (Last, First)	Relationship	Date of Birth	SSN	%	Contingent* Y/N
Name (Last, First)	Relationship	Date of Birth	SSN	%	Contingent* Y/N
Name (Last, First)	Relationship	Date of Birth	SSN	%	Contingent* Y/N

*Contingent: meaning benefit will be split.

VOLUNTARY LIFE/AD&D INSURANCE~ For employees who work twenty (20) or more hours per week.

- ☐ I elect to waive / cancel
- ☐ No change from previous year
- ☐ Employee Life $ _____
  (Increments of $10,000 up to $500,000 not to exceed 5 X salary)
  *Guaranteed Issue Amount ~ $150,000
- ☐ Spouse Life $ _____
  (Increments of $5,000 up to $100,000)
  *Guaranteed Issue Amount ~ $25,000
- ☐ Employee AD&D $ _____
  (Increments of $10,000 up to $500,000 not to exceed 5 X salary)
  *Guaranteed Issue Amount ~ $150,000
- ☐ Spouse AD&D $ _____
  (Increments of $5,000 up to $100,000)
  *Guaranteed Issue Amount ~ $25,000
- ☐ Child(ren) $ _____
  Increments of $1,000 up to $10,000 for children age 6 months to 19 years of age 26 if unmarried and full-time student
  *Guaranteed Issue Amount ~ $10,000

*The amount a new hire or newly eligible employee can elect without completing underwriting paperwork.

DEPENDENT SECTION

Dependent Information ~ You must complete the following by entering the information for each dependent and putting an "X" in each applicable benefits box.

Name (Last, First, Middle Initial)	Social Security Number	Relationship to Employee	Gender (M/F)	Date of Birth MM/DD/YY	Medical	Dental	Vision	Vol Life

Declaration Section

By signing below, I acknowledge that I have read and understand the benefits in the Benefits Guide and in this enrollment form. I authorize the required payroll deductions for contributory benefits. I also represent that all information shown on this enrollment form is correct and realize that any false statement or misrepresentation in this form may result in the loss of coverage under this policy. I also acknowledge that any dependent added to medical, dental or vision benefits does not currently have access to or is currently not covered under any other employer plans (Simplan may require additional information to confirm duplicate coverage does not exist.) I also understand Wisconsin Illinois Senior Housing retains the right to conduct a Dependent Verification Audit at anytime to validate my dependent(s)' eligibility.

Employee Signature _____ Date _____

For Official Use Only:

Entered By: _____ Date: _____ Location: _____