LAKESIDE INDUSTRIES

Benefit Enrollment Form

January 1 – December 31, 2020

ENROLLMENT REASON:

☐ Open Enrollment ☐ New Hire (Initial Eligibility) ☐ COBRA ☐ Coverage Change (check additional box below)

☐ Drop Spouse*/Dependent ☐ Add Spouse*/Dependent ☐ Voluntary Termination

Reason: _____Effective Date of Coverage/Change: _____

Instructions: This form provides you with the different options you may elect. You must complete this form and return it to Human Resources. Indicate your benefit choice by checking the box next to the desired benefit options. Dental benefits underwritten by Delta Dental of Washington.

HMA #020465
10700 Northup Way #100, Bellevue, WA 98004

Delta Dental of Washington #03826
400 Fairview Ave N, Suite 800, Seattle, WA 98109

Section 1: Employee Information			
Employee Name:		SSN:	
Date of Hire:		Division:	
Address:		City, State, Zip:	
Date of Birth:		Job Title:	
Gender:	☐ Male ☐ Female	Phone:	
Marital Status:	☐ Single ☐ Married ☐ Divorced		
E-mail Address:			

Section 2: Plan Elections *(check one box for each plan or check No Changes)*

☐ NO CHANGES

	Employee only	Employee + spouse*	Employee + children	Employee + family	Waive	Reason for waiving medical coverage:
Medical/Rx Plan HMA Health Savings Plan	☐	☐	☐	☐	☐	☐ I am covered by my spouse's* medical plan ☐ I am covered by my parent's medical plan ☐ I am covered by Medicare (generally for age 65+) ☐ I am covered by Medicaid ☐ I have other medical coverage not listed above ☐ I choose not to have medical coverage ☐ Other _____
Dental Plan Delta Dental of WA PPO Plan	☐	☐	☐	☐	☐	
Vision Reimbursement Program	☐	☐	☐	☐	☐	
Basic Life/AD&D insurance Sun Life	☐	N/A	N/A	N/A	☐	
Long Term Disability Insurance Sun Life	☐	N/A	N/A	N/A	☐	

Section 3: Dependent Information *(update or check No Changes)*						
☐ NO CHANGES						
Check One		Dependent's Name	Date of Birth	Social Security #	Relationship	Gender
Add	Delete	First MI Last				
☐	☐				☐ Spouse* ☐ Child	☐ Male ☐ Female
☐	☐				☐ Spouse* ☐ Child	☐ Male ☐ Female
☐	☐				☐ Spouse* ☐ Child	☐ Male ☐ Female
☐	☐				☐ Spouse* ☐ Child	☐ Male ☐ Female
☐	☐				☐ Spouse* ☐ Child	☐ Male ☐ Female

Section 4: Wellness Program Incentive for Employees Not Eligible for the HSA (*skip if you are HSA eligible*)		
If you are not eligible for the HSA, Lakeside will put your wellness incentive in a limited purpose health FSA. This limited purpose health FSA reimburses for dental and vision care expenses only. If you think you will become eligible for the HSA prior to December 1, 2020 you may elect to defer receiving your wellness program incentive until you become HSA eligible.		
☐ I want to receive my wellness program incentive for the 2020 plan year via a contribution to a limited purpose health FSA. (The health FSA limit must be aggregated. Lakeside's contribution to your Limited Purpose Health FSA counts towards your health FSA limit for 2020.)	OR	☐ I elect to defer receiving my wellness program incentive for the 2020 plan year until I am HSA eligible. (You must become HSA eligible prior to December 1, 2020. If not, you will lose your 2020 wellness program incentive.)

Section 5: Other Medical/Rx and Dental Coverage Information *(Update or check No Changes)*		
☐ NO CHANGES		
Do you or your dependents have medical/Rx or dental coverage under another health care plan (including COBRA coverage)?	☐ No (skip to Section 6)	☐ Yes (complete the rest of this section)
Name of policy holder:	Member ID #:	
	Date coverage began:	
Name and address of insurance carrier:	Covered members (list all):	

Section 6: Basic Life/AD&D Beneficiary Designation *(update or check No Changes)*							
☐ NO CHANGES							
Beneficiaries	Name	Relationship	Address	SSN	Date of Birth	Phone #	%*
Primary 1							
Primary 2							
Secondary 1							
Secondary 2							

*The total within each class (Primary and Secondary) must equal 100%.

Section 7: Signature and Date

By my signature below, I acknowledge and agree to the following terms and conditions:

- I have been provided with an enrollment packet.
- November is the open enrollment period and my annual opportunity to make any changes to my employee benefit plan elections.
- In accordance with IRS Section 125 rules, I am unable to make changes to my elections until January 1, 2021, unless I or my eligible dependents experience an event that permits a mid-year election change. (HSA elections may be changed monthly).
- Eligible dependents include my legally married spouse* and my child(ren) up to age 26. It is my responsibility to notify Lakeside Industries if any covered dependent ceases to meet the definition of an eligible dependent. If I cover an individual on the employee benefit plan who is not an eligible dependent, this is considered fraud and theft, and may be grounds for termination of employment.
- Pre-tax compensation reductions will reduce my taxable income for Social Security purposes and may result in a reduction of Social Security benefits that I, or my dependents, may become entitled to in the future.
- If I fail to execute a Benefit Enrollment Form by November 9, I will be deemed to have waived health coverage for myself and any eligible dependents, and any coverage currently in force will be cancelled effective January 1, 2020.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee Signature: _____ Date:_____

*For the Delta Dental of Washington Dental Plan only: References to marriage, divorce and spouse apply equally to registered domestic partners. State-registered domestic partners are eligible for the dental benefits only.