WORLD WIDE MOVERS, INC.

BENEFIT SELECTION/COMPENSATION REDUCTION FORM
Effective January 1 – December 31, 2020

Employee's Name _____SSN_____

Employee's Address _____

City/State/Zip _____Hire Date _____Birth Date _____

I elect the following enrollment in World Wide Movers, Inc.'s benefit plans:
Pre-tax deductions per month (check one box for medical/prescription drug coverage and one box for dental coverage)

Medical/Prescription Drug/Vision Plan – Premera Blue Cross

☐ **Employee only**	$114.51	
☐ **Employee + non-working spouse** *(Spouse does not have access to medical insurance through another employer)*	$444.05	☐ **I elect to waive Medical/Prescription Drug/Vision coverage.**
☐ **Employee + working spouse** *(Spouse has access to medical insurance through another employer)*	$544.05	Please explain why you are electing to waive coverage:
☐ **Employee + children**	$400.36	☐ I have coverage through my spouse/domestic partner
☐ **Employee + non-working spouse + children** *(Spouse does not have access to medical insurance through another employer)*	$686.04	☐ I have coverage through my parents
☐ **Employee + working spouse + children** *(Spouse has access to medical insurance through another employer)*	$786.04	☐ Other: _____

Dental Plan – Premera Blue Cross

☐ **Employee only**	$6.74	☐ **I elect to waive Dental coverage.**
☐ **Employee + spouse**	$10.06	Please explain why you are electing to waive coverage:
☐ **Employee + children**	$39.91	☐ I have coverage through my spouse/domestic partner
☐ **Employee + spouse + children**	$43.25	☐ I have coverage through my parents
		☐ Other: _____

I agree to have the above monthly total amounts deducted from my paycheck on a pre-tax basis as payment for insurance coverage for myself and/or any dependent(s). I will notify HR if I wish to have these deductions taken on a post-tax basis.

I hereby certify that:

- I have been provided with an enrollment packet including a summary of the plan benefits.
- I understand that **December 9 – 13** is the open enrollment period and this is my opportunity to make any changes to my participation in the Employee Benefit Plan.
- I understand IRS Section 125 regulates that I will not be eligible to make changes to my participation in the Employee Benefit Plan until January 1, 2021 (unless I or my eligible dependents experience a permitted mid-year election change event).
- An election to reduce compensation under the Plan will reduce my compensation for Social Security purposes and may result in a reduction of Social Security benefits that I, or my family, may become entitled to in the future.

_____ _____

Employee Signature Date