



BENEFIT SELECTION/COMPENSATION REDUCTION FORM
Effective January 1 – December 31, 2021

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 \$116
Employee + non-working spouse \$449
Employee + working spouse \$549
Employee + children \$405
Employee + non-working spouse + children \$693
Employee + working spouse + children \$793

I elect to waive Medical/Prescription Drug/Vision coverage.

Please explain why you are electing to waive coverage:

- I have coverage through my spouse/domestic partner
I have coverage through my parents
Other: _____

Dental Plan – Premera Blue Cross

- Employee only \$7
Employee + spouse \$10
Employee + children \$40
Employee + spouse + children \$44

I elect to waive Dental coverage.

Please explain why you are electing to waive coverage:

- I have coverage through my spouse/domestic partner
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 November 30 – December 18, 2020 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, 2022 (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.

By checking this box and typing my name below, it is my intent to electronically sign and electronically submit this form. I understand that by checking this box and typing my name below, I will be applying my electronic signature to this form and that I will be bound with the same force and effect as if I had signed this form on paper by hand.

Employee Name _____

Date _____