WORLD WIDE MOVERS, INC.

BENEFIT SELECTION/COMPENSATION REDUCTION FORM
Effective January 1 – December 31, 2022

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** *(Spouse does not have access to medical insurance through another employer)*	$449
☐ **Employee + working spouse** *(Spouse has access to medical insurance through another employer)*	$549
☐ **Employee + children**	$405
☐ **Employee + non-working spouse + children** *(Spouse does not have access to medical insurance through another employer)*	$693
☐ **Employee + working spouse + children** *(Spouse has access to medical insurance through another employer)*	$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 **December 1 - 10, 2021** 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, 2023 (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