



WORLD WIDE MOVERS, INC.

BENEFIT SELECTION/COMPENSATION REDUCTION FORM
Effective January 1 – December 31, 2023

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 \$128
Employee + non-working spouse \$494
Employee + working spouse \$594
Employee + children \$446
Employee + non-working spouse + children \$762
Employee + working spouse + children \$862

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 – 9, 2022 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, 2024 (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 _____