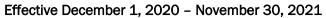
Benefit Selection/Compensation Reduction Form







Employee's Name:							
		,					
If newly enrolling dependents, please of Dependent Full name		e complete: Date of Birth	Social Security Number	Sex [M or F]	Address (if different from yours)		
l e	ect the following as monthly, p	 ore-tax deduction	 s:		1		
Ме	dical/Prescription Drug:						
	se Medical Plan – Regence Class	ic \$3,000 Deductil	ole PPO Buy-Up Plan	Medical -	Regence Innova	\$1,000 Deductible PPC	
	Employee Only	\$0.00	☐ Em	ployee Only	y	\$149.80	
	Employee + Spouse/DP*	\$0.00	☐ Em	☐ Employee + Spouse/DP* \$332.00			
	Employee + Child(ren)	\$0.00	☐ Em	_ ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			
	Employee + Family	\$0.00	☐ Em	ployee + Fa	amily	\$471.90	
l el	ect to waive medical coverage be	cause (choose one	e of the following):				
	I have other employer-sponsored I have coverage through the Hearketplace		☐ I have coverage through Medicare, Medicaid or Tricare☐ I don't want medical coverage				
De	lta Dental		<u>Vision</u>				
	Employee Only	\$42.95	☐ Emplo	oyee Only		\$0.00	
	Employee + Spouse/DP*	\$89.50	•			\$0.00	
	Employee + Child(ren)	\$93.05	•	oyee + Chil	\$0.00		
	Employee + Family	\$139.60	☐ Emplo	oyee + Fam	\$0.00		
	I elect to waive dental		☐ I elec	t to waive v	vision		
Employee Base Life Insurance			Employee	Employee Base Long-Term Disability			
	Employee Only	\$0.00	Emplo	yee Only	\$0.00		
	I elect to waive base life insurar	☐ I elect	☐ I elect to waive base LTD				
	Life - Spouse/DP* \$	List amount req List amount req List amount req	quested in \$10,000 uested for each chi	increment ld, in \$2,00	ts up to \$300,00 00 increments up	o to \$10,000	

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

- I have been provided with an enrollment guide, including a Summary of Benefits and Coverage.
- November is the open enrollment period, and is 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 employee benefit plan elections until December 1, 2021, unless I or my eligible dependents experience an event that permits a mid-year election change.
- Eligible dependents include my legally married spouse, domestic partner and my and/or my spouse/DP's dependent children up to age 26. It is my responsibility to notify TRICO Companies if any covered dependent ceases to meet the definition of an eligible dependent under the terms of the employee benefit plan. 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.
- Payroll deductions will be taken from my paycheck on a pre-tax basis to pay for my portion of the premiums for the employee benefits that I elect. It is my responsibility to notify Human Resources if I want premiums deducted on an after-tax basis.
- 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.
- *DP=Domestic Partner; Under federal tax law, unless my domestic partner (or his/her child[ren]) qualifies as a tax dependent, premiums may not be paid on a pre-tax basis. In addition, the value of my domestic partner's coverage, less the amount paid by me for such coverage on an after-tax basis, will be included in my gross income, subject to federal withholding and employment taxes.

Signature	Date