Insurance Packet Receipt 2019

Kinex / R&M Holdco, LLC

Insurance Packet Receipt Form

I have received the insurance information from Kinex / R&M Holdco, LLC. that details the medical insurance benefits through United Healthcare for open enrollment at this time. I understand the effective date of my election is August 1, 2019.

I also understand it is my responsibility to read through the benefits information and to complete the enrollment form attached and return to Human Resources by XXXX, 2019.

I understand that if I choose to waive participation in the insurance plans of Kinex / R&M Holdco, LLC, I will NOT be enrolled in the medical plan. I need to complete the enrollment forms, mark that I am waiving participation and return the forms to the HR Manager by XXXX, 2019

I understand that if I do not return the enrollment forms to Human Resources by the date of the benefit becoming effective or by the end of the grace period that I will continue my waived status or be automatically enrolled in the Health Plan with HRA if currently enrolled. Changes cannot be made until the subsequent open enrollment or if a qualifying life event takes place.

By signing this I am also confirming that the Company has provided me the Federal Healthcare Updates for 2019.

_____ _____

Employee Date

Kinex / R&M Holdco, LLC
Election Form

Kinex / R&M Holdco. offers one health plan with two different employer contribution options. Please make your elections below, sign, and return this form to HR. If you do not wish to participate in a plan, please check the box(es) marked "waive", sign and return this entire form.

Entire Section Filled out

Employee Name (First)_____(MI)_____(Last) _____

Address:		
Phone:	Current Status (Medicare/COBRA/Active):	
Date of Birth: Gender:	Social Security Number:	
Email:	Mail/Email Preference:	Date of Hire:
Job Title:	Hours worked per week:	Marital Status/Date of Marital Status:

If applicable → Dependent Information (if electing benefits to include family members):

Name (First, MI, Last)	Relationship	Date of Birth	Gender	Social Security Number

Dependent Address, if different from employee_____

Dependent Phone Number, if different from employee_____

Employee Name (First)_____(MI)_____(Last)_____

Health Insurance

Effective Date: _____

I choose the following health insurance coverage:

- ◯ **Health Plan with HSA - $600 Employer Contribution**
  UHC $3,500 Single / $7,000 Family Plan with Health Savings Account (HSA)
- ◯ **Health Plan with HRA - $650 single / $1,300 Family Reimbursement**
  UHC $3,500 Single / $7,000 Family Plan with Health Reimbursement Account (HRA)
- ◯ **Waive:** I choose to not participate in Kinex / R&M Holdco, LLC group health insurance.
  Please check applicable reason(s):
  - ☐ Spousal Coverage
  - ☐ Medicare Related Coverage
  - ☐ Individual Coverage
  - ☐ Coverage Under Another Group Plan
  - ☐ Other _____

Select HSA, HRA or waive

Please choose one of the following coverage categories if you are not waiving coverage:
(If you are enrolling one or more dependent(s), please complete page 2 as well)

- ◯ Employee Only
- ◯ Employee/Child(ren)
- ◯ Employee/Spouse
- ◯ Employee + Family

If enrolling select type of coverage.

Health Reimbursement Account or Health Savings Account

If you chose HSA please sign if statement is applicable →

Health Savings Account – Refer to the Optum HSA materials to open your Health Savings Account and to receive the annual Kinex contribution of $600 deposited in monthly amounts of $50.

_____ (Initial) Medicare eligible employees cannot contribute to the HSA or receive employer funds in an HSA. Those enrolled in the HSA cannot utilize the Nurse Practitioner on-site (if applicable).

I wish to contribute an annual election in addition to the employer contribution:

_____ ($2,900 single / $6,400 family maximum)

Health Reimbursement Account – Kinex will provide the reimbursement up to $650 single or $1,300 family through TASC. See TASC materials for the reimbursement process.

Employee Name (First)_____(MI)_____(Last)_____

Flexible Spending Account

Flexible Spending accounts are pre-tax contributions for spending during the current plan year. These accounts are "use it or lose it" and enrollees are responsible for understanding the terms of the plan.

- ◯ Medical Flexible Spending Account (if enrolled in the HRA)
- ◯ Limited Medical Flexible Spending Account (if enrolled in any HSA)
- ◯ Waive

Annual election ($2,700 maximum) _____

- ◯ Dependent Care Flexible Spending Account (not tied to any medical plan)
  - For dependent children 13 and younger or spouse/adult dependent incapable of self-care and lives in your home.
- ◯ Waive

Annual election ($5,000 maximum) _____

_____ Initial to acknowledge that Flexible Spending Plans are "use it or lose it" for eligible claims during the plan year.

Authorization

I will pay for the benefits selected above in accordance with the terms of the plan. My pay will be reduced by the amount that I am required to pay for coverage I have selected under this plan, effective with the date of this election, and continuing for each succeeding pay period until the end of the plan year for any benefits selected. In a no-pay situation such as leave, my repayment options will be provided to me. If employment or benefits end for any reason, all contributions due will be deducted from my last paycheck.

I cannot change or revoke this benefit election or compensation reduction agreement until the next Open Enrollment period unless I have a change in family status (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, and such other events as the Plan Administrator determines will permit a change or revocation of an election). I must notify HR within 30 days of the event to make an eligible change.

_____ Deductions will be made on a **pre-tax basis** if initialed here. If not initialed, the deductions will be post-tax.

_____ _____

Employee Date