Kinex / Group Health Plan Enrollment / Change Form

EMPLOYER INFORMATION	
Employer Name:	**Kinex Medical Company**
Employer Location:	**1801 Airport Road, Ste D, Waukesha, WI 53188**

ENROLLMENT TYPE	FOR CHANGES IN COVERAGE ONLY	
☐ **New Employee** ☐ **Change in Coverage** ☐ **Annual Enrollment** ☐ **Other** **Effective Date:** _____	Change Request:	☐ Name Change ☐ Address Change ☐ Beneficiary Change ☐ Add Dependents ☐ Delete Dependents Reason: _____ ☐ Marriage ☐ Divorce or Legal Separation ☐ Birth or Adoption ☐ COBRA Qualifying Event: _____ ☐ Other _____

EMPLOYEE INFORMATION						
Last Name	**First**	**Middle**	**Suffix**	☐ **Male** ☐ **Female**	**Date of Birth**	**Social Security No.**
Street Address		**City**		**State**	**Zip**	**Home Phone**
Email Address						**Cell Phone**
Marital Status						

SPOUSE INFORMATION					
Spouse – Last Name	**First**	**Middle**	**Suffix**	☐ **Male** ☐ **Female**	**Date of Birth**
Spouse's Cell Phone	**Spouse's Employer (Name and Address)**				**Social Security No.** **Date of Marriage**

DEPENDENT INFORMATION					
1.	**First Name**	**Middle**	**Last**	☐ Male ☐ Female	**Date of Birth**
Relationship to Subscriber	**Disabled:** ☐ Yes ☐ No	**Social Security Number**			**Home/Cell Phone**
Street Address (if different from subscriber)		**City**			**State** / **Zip**
2.	**First Name**	**Middle**	**Last**	☐ Male ☐ Female	**Date of Birth**
Relationship to Subscriber	**Disabled:** ☐ Yes ☐ No	**Social Security Number**			**Home/Cell Phone**
Street Address (if different from subscriber)		**City**			**State** / **Zip**
3.	**First Name**	**Middle**	**Last**	☐ Male ☐ Female	**Date of Birth**
Relationship to Subscriber	**Disabled:** ☐ Yes ☐ No	**Social Security Number**			**Home/Cell Phone**
Street Address (if different from subscriber)		**City**			**State** / **Zip**
4.	**First Name**	**Middle**	**Last**	☐ Male ☐ Female	**Date of Birth**
Relationship to Subscriber	**Disabled:** ☐ Yes ☐ No	**Social Security Number**			**Home/Cell Phone**
Street Address (if different from subscriber)		**City**			**State** / **Zip**

OTHER MEDICAL COVERAGE or MEDICARE

Do you or any of your dependents have any other Medical Coverage? ☐ **Yes** ☐ **No** Dental Coverage? ☐ **Yes** ☐ **No** Medicare? ☐ **Yes** ☐ **No**

If yes, Policy No.:	Policy Holder:	Insurer Name:	Covered Individuals:

MEDICAL COVERAGE ELECTION (Humana)

Medical Plan / Select all that apply (must cover employee to cover any dependents)

- ☐ Employee Only ($57.81 bi-weekly / $125.25 monthly)
- ☐ Employee + Spouse ($173.42 bi-weekly / $375.74 monthly)
- ☐ Employee + Child(ren) ($161.86 bi-weekly / $350.69 monthly)
- ☐ Family ($312.15 bi-weekly / $676.33 monthly)

☐ Waive Coverage Reason: _____

DENTAL & VISION COVERAGE ELECTIONS (Delta Dental of Wisconsin)

Dental Plan

- ☐ Employee Only ($2.53 bi-weekly / $5.48 monthly)
- ☐ Employee + Spouse ($8.86 bi-weekly / $19.20 monthly)
- ☐ Employee + Child(ren) ($9.27 bi-weekly / $20.09 monthly)
- ☐ Family ($16.49 bi-weekly / $35.73 monthly)

☐ Waive Coverage

Vision Plan

- ☐ Employee Only ($2.83 bi-weekly / $6.14 monthly)
- ☐ Employee+ Spouse ($5.38 bi-weekly / $11.66 monthly)
- ☐ Employee + Child(ren) ($6.30 bi-weekly / $13.65 monthly)
- ☐ Family ($8.87 bi-weekly / $19.22 monthly)

☐ Waive Coverage

BASIC LIFE, STD AND LTD (Mutual of Omaha)

Basic Life Beneficiaries: (Beneficiaries must total 100%)

Primary Beneficiary:
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____

Basic Life Contingent Beneficiary: (Beneficiaries must total 100%)
(In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information).

Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____

Automatic Elections:

<u>Basic Life</u> – Employee is automatically enrolled at 100% of your annual salary (rounded to the nearest $1,000) to a maximum of $250,000.

<u>Short Term Disability (STD)</u> – Employee is automatically enrolled in this company-paid benefit.

<u>Long Term Disability (LTD)</u> – Employee is automatically enrolled at a monthly benefit of 60% of salary.

VOLUNTARY TERM LIFE INSURANCE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) - (Mutual of Omaha)

NOTE: If you currently have Voluntary Life coverage <u>above the guarantee issue</u> amount with The Standard, that amount will transfer over to Mutual of Omaha unless you indicate otherwise. Contact Human Resources if you have questions on how much you have previously elected.

You must be enrolled to cover your dependents. Age-related benefit reductions apply. Please see plan administrator. Based on your plan benefits and age, you may be required to complete a health questionnaire for Voluntary Life.

Employee:
Policy Amount (check one box only)

- ☐ $10,000
- ☐ $20,000
- ☐ $30,000
- ☐ $40,000
- ☐ $50,000
- ☐ $60,000
- ☐ $70,000
- ☐ $80,000
- ☐ $90,000
- ☐ **$100,000*** *Guarantee Issue Amount
- ☐ $110,000
- ☐ $120,000
- ☐ $130,000
- ☐ $140,000
- ☐ $150,000
- ☐ $160,000
- ☐ $170,000
- ☐ $180,000
- ☐ $190,000
- ☐ $200,000
- ☐ $210,000
- ☐ $300,000

*Guarantee Issue Amount

☐ I do not want this coverage

Voluntary Life Primary Beneficiary: (Beneficiaries must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____

Voluntary Life Contingent Beneficiary: **(Beneficiaries must total 100%**)
(In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information).
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____
Name: _____
%: _____
Relationship to employee: _____

Add Voluntary Life for Spouse:
Policy Amount (check one box only)

- ☐ $5,000
- ☐ $10,000
- ☐ $15,000
- ☐ **$20,000*** *Guarantee Issue Amount
- ☐ $25,000
- ☐ $30,000
- ☐ $35,000
- ☐ $40,000
- ☐ $45,000
- ☐ $50,000
- ☐ $55,000
- ☐ $60,000
- ☐ $65,000
- ☐ $70,000
- ☐ $75,000
- ☐ $80,000
- ☐ $85,000
- ☐ $90,000
- ☐ $95,000
- ☐ $100,000
- ☐ $150,000

***The amount may not be more than 50% of the employee amount for Voluntary Life**

☐ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren) - Covers all children for one price

Policy Amount (check one box only)

- ☐ $5,000
- ☐ $10,000*

*Guarantee Issue Amount

☐ I do not want this coverage

HEALTH CARE FLEXIBLE SPENDING (If not enrolled in Kinex medical plan)	DEPENDENT CARE FLEXIBLE SPENDING
Per pay period election: $ _____ **Total annual election: $ _____** ☐ I do not want this coverage **Annual Maximum Contribution Limit:** $2,850	**Per pay period election: $ _____** **Total annual election: $ _____** ☐ I do not want this coverage **Annual Maximum Contribution Limit:** $5,000 for single taxpayers and married couples filing jointly, or $2,500 for married people filing separately.

LIMITED PURPOSE FLEXIBLE SPENDING (If enrolled in Kinex medical plan)

Per pay period election: $ _____

Total annual election: $ _____

☐ I do not want this coverage

HEALTH SAVINGS ACCOUNT (HSA)

Per pay period election: $ _____

Total annual election: $ _____

☐ I do not want this coverage

2022 Maximum Contribution Limits (including Kinex employer contributions of $50/month): Employee Only: $3,650
EE+1 or Family: $7,300, and those age 55+ an additional $1,000

Authorization

I enroll (or decline to enroll) for the benefits indicated in the various COVERAGE sections above which will be provided by the Group Plans for which I am eligible. 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(s) selected above, effective as of January 1, 2022, and continuing each pay period until the end of the plan year (calendar year). In a no-pay situation such as leave, I agree to either pay the contributions on an after-tax basis during my leave or I provide Kinex Medical Company the authorization to deduct any and all due contributions from any funds/monies I may be eligible to receive during my leave. Any remaining funds due upon my return from leave will be deducted from any funds/monies (including my paycheck) on a pre-tax basis upon my return and until all accrued contributions are paid back to the company in full. If employment or benefits end for any reason (during my leave or after my return from leave), all contributions due will be deducted from any funds/monies due to me including my last paycheck(s).

I understand I am not able to change or revoke this benefit election or compensation reduction agreement until the next Open Enrollment period. Any contribution changes would be effective at the beginning of the plan year that coincides with the open enrollment period. The exception is 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). Per IRS regulations, I must notify HR and provide acceptable proof consistent with the requested change within 30 days of the event for the change to be permissible.

I understand that all deductions (employee contributions) for the medical, dental, vision, health savings funds and flexible spending accounts elected above will be made pre-tax unless I indicate in writing to Human Resources at or before the beginning of the plan year to have the fund/monies deducted on a post-tax basis. The exception to the post-tax contributions is an absence/leave from work discussed above.

I authorize any physician, medical practitioner, hospital, clinic or medical related facility, insurance or reinsuring company, having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment for myself, my spouse, or my minor children and any other non-medical information for myself, my spouse, or my minor children to give Humana or their legal representative, any and all such information. Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Plan Administrator, the Plan Sponsor, Plan consultants, insurance intermediaries, or other persons or organizations performing business or legal services in connection with my application, claim, the Plan renewal, or as may be otherwise lawfully required or as I may further authorize.

Insurance Receipt

I have received the insurance information from Kinex Medical Company that details the health and welfare benefits available during open enrollment. I understand the effective date of my election is January 1, 2022. I also understand it is my responsibility to read through the benefits information and to complete this enrollment form and return it to Human Resources by **December 17, 2021**. By signing this I am also confirming that the Company has provided me all applicable federal health care and human resources updates and required annual notices for 2022.

I hereby certify that the information shown above is true and correct to the best of my knowledge. I understand that any false information may result in my coverage being cancelled and that I may be responsible to reimburse the Company for any benefits paid to me. The Company reserves the right to rescind coverage should the above information prove to be false or inaccurate, and to take any other disciplinary action the Company deems appropriate up to and including termination of my employment.

_____ _____

DATE **SIGNATURE OF EMPLOYEE – APPLICANT**