HR Use Only

Annual Salary _____________

Class ______________

Location _________________

MARSH & McLENNAN AGENCY

2017 Benefits Election Form
For Plan Year: January 1, 2017 through December 31, 2017

Section 1: Employee Information

Employee Name: ____ Social Security #: _________________________

Date of Birth: _______________________ Sex: ☐ M ☐ F Marital Status: ____________________

Address: ____ City: _________________________ State: ________ Zip: _____________

Occupation: _____________________________________ Date of Hire: ___________________

Section 2: Medical *BlueCross & BlueShield of NC*

Please Indicate Your Medical Election:

	Monthly Payroll Deductions
☐ Employee Only	$ 95.00
☐ Employee + One	$285.00
☐ Family	$550.00

☐ **Waive – I do not wish to enroll in medical coverage.**

Section 3: Dental *MetLife*

Please Indicate Your Dental Election:

	Monthly Payroll Deductions
☐ Employee Only	$ 33.87
☐ Employee + Spouse	$ 64.39
☐ Employee + Child(ren)	$ 87.75
☐ Family	$131.33

☐ **Waive – I do not wish to enroll in dental coverage.**

Section 4: Vision *Vision Service Plan*

Please Indicate Your Vision Election:

	Monthly Payroll Deductions
☐ Employee Only	$ 8.72
☐ Employee + Spouse	$17.42
☐ Employee + Child(ren)	$18.65
☐ Family	$29.80

☐ **Waive – I do not wish to enroll in vision coverage.**

Section 5: Dependent Information (If Enrolling)

Dependent 1: ☐ Medical ☐ Dental ☐ Vision   Relationship: ☐ Spouse ☐ Child

Name: ______________________________   Sex: ☐ Male ☐ Female

Date of Birth: ______________________

Dependent 2: ☐ Medical ☐ Dental ☐ Vision   Relationship: ☐ Spouse ☐ Child

Name: ______________________________   Sex: ☐ Male ☐ Female

Date of Birth: ______________________

Dependent 3: ☐ Medical ☐ Dental ☐ Vision   Relationship: ☐ Spouse ☐ Child

Name: ______________________________   Sex: ☐ Male ☐ Female

Date of Birth: ______________________

Dependent 4: ☐ Medical ☐ Dental ☐ Vision   Relationship: ☐ Spouse ☐ Child

Name: ______________________________   Sex: ☐ Male ☐ Female

Date of Birth: ______________________

Dependent 5: ☐ Medical ☐ Dental ☐ Vision   Relationship: ☐ Spouse ☐ Child

Name: ______________________________   Sex: ☐ Male ☐ Female

Date of Birth: ______________________

Section 6: Dependent Basic Life Insurance *The Hartford*

Employees may purchase dependent life insurance in the amount of $10,000 for your spouse and $5,000 for your dependent children over 6 months old. For dependent children from birth to 6 months, coverage will be in the amount of $500.

*Your cost for this coverage is **$2.40 per month**.*

☐ **Yes, I wish to enroll for Dependent Basic Life benefits**

☐ **No, I do not wish to enroll for Dependent Basic Life benefits**

Section 7: Employer Paid Benefits

Elect	*Type of Coverage*	*Amount of Coverage*	*Carrier*
X	*Basic Life – Paid 100% by Pfeiffer University*	*2x Salary up to $250,000*	*The Hartford*
X	*Basic AD&D – Paid 100% by Pfeiffer University*	*2x Salary up to $250,000*	*The Harford*
X	*Long Term Disability – Paid 100% by Pfeiffer University*	*Up to $7,500 monthly*	*The Hartford*
X	*Teladoc – Paid 100% by Pfeiffer University*		

Section 8: Voluntary Life Insurance — *The Hartford*

Employees may purchase Life Insurance in $10,000 increments up to a maximum of $200,000. (Minimum election amount: $20,000.) Additionally, Life Insurance may be purchased for your spouse in $5,000 increments, not to exceed 50% of the employee's covered life amount. (Spouse guarantee issue amount: $50,000. EOI required for higher limits.) Life coverage for children is available in $2,000 increments up to a maximum of $10,000. Spouse rate is based upon employee age.

Age	Monthly Rate Per $1,000
<19	0.08
20-24	0.08
25-29	0.08
30-34	0.08
35-39	0.09
40-44	0.14
45-49	0.22
50-54	0.36
55-59	0.63
60-64	1.01
65-69	1.52
70+	2.72
AD&D	included
Child(ren)	0.22

☐ **Yes, I wish to enroll for Supplemental Life/AD&D insurance.** (You will need to complete an enrollment form and health questionnaire if you are electing above the Guarantee Issue amount or for the first time. Coverage is subject to approval. Please see HR for the forms.)

$_____________ Employee Life Amount

$_____________ Spouse Life Amount

$_____________ Child(ren) Life Number of children to be covered _______

☐ **No, I do not wish to enroll for Supplemental Life/AD&D insurance**

Section 9: Life Insurance Beneficiaries

The person(s) you indicate as a primary beneficiary will receive the life insurance benefit upon the employee's death. In the event the primary beneficiary is not living at the time of the employee's death, the contingent beneficiary will receive the life insurance benefit.

All employees must designate at least one beneficiary for company-paid basic life insurance.

	Full Name	Date of Birth	Relationship	Percentage
Primary				
Primary				
Contingent				
Contingent				

Section 10: Accident Insurance — *The Hartford*

Please Indicate Your Accident Election:

	Monthly Payroll Deductions
☐ Employee Only	$12.33
☐ Employee + Spouse	$19.38
☐ Employee + Child(ren)	$20.34
☐ Family	$32.88

☐ **Waive – I do not wish to enroll in Accident coverage.**

Section 11: Critical Illness Insurance

The Hartford

Employees may purchase Critical Illness coverage in the amount of $10,000 or $20,000. Additionally, coverage may be purchased for your spouse at 100% of the employee election. Coverage for dependent children is in the amount of $10,000. Guaranteed Issue amount is $20,000 for employees and all amounts for spouse and children.

Age	Monthly Rate – Non Smoker							
	Employee - $10,000	Employee - $20,000	Employee & Spouse - $10,000	Employee & Spouse - $20,000	Employee & Child - $10,000	Employee & Child - $20,000	Family - $10,000	Family - $20,000
<19	$3.23	$5.08	$6.43	$10.14	$7.19	$9.04	$11.33	$15.05
20-24	$3.23	$5.08	$6.43	$10.14	$7.19	$9.04	$11.33	$15.05
25-29	$4.01	$6.53	$7.93	$12.93	$7.97	$10.48	$12.84	$17.84
30-34	$5.06	$8.56	$10.00	$16.93	$9.02	$12.52	$14.91	$21.84
35-39	$6.95	$12.28	$13.70	$24.25	$10.91	$16.24	$18.61	$29.15
40-44	$10.77	$19.77	$21.34	$39.22	$14.72	$23.73	$26.25	$44.13
45-49	$16.54	$31.19	$33.23	$62.71	$20.50	$35.14	$38.14	$67.62
50-54	$23.49	$45.02	$47.74	$91.61	$27.45	$48.98	$52.65	$96.51
55-59	$32.02	$62.03	$65.74	$127.49	$35.98	$65.99	$70.65	$132.40
60-64	$46.27	$90.45	$95.61	$187.09	$50.23	$94.41	$100.52	$192.00
65-69	$64.48	$126.80	$132.85	$261.43	$68.44	$130.76	$137.75	$266.33
70-74	$45.45	$88.70	$93.60	$182.82	$48.06	$91.30	$96.83	$186.05
75-79	$59.98	$117.76	$123.14	$241.91	$65.28	$120.37	$126.37	$245.14

Age	Monthly Rate – Smoker							
	Employee - $10,000	Employee - $20,000	Employee & Spouse - $10,000	Employee & Spouse - $20,000	Employee & Child - $10,000	Employee & Child - $20,000	Family - $10,000	Family - $20,000
<19	$3.41	$5.45	$6.81	$10.90	$7.37	$9.41	$11.71	$15.81
20-24	$3.41	$5.45	$6.81	$10.90	$7.37	$9.41	$11.71	$158.81
25-29	$4.41	$7.33	$11.85	$14.63	$78.37	$11.29	$13.68	$19.53
30-34	$5.94	$10.31	$17.71	$20.62	$9.90	$14.26	$16.76	$25.53
35-39	$8.84	$16.05	$13.70	$32.24	$12.80	$20.01	$22.62	$37.15
40-44	$15.18	$28.58	$30.79	$58.07	$19.14	$32.54	$35.70	$62.98
45-49	$26.33	$50.69	$54.18	$104.46	$30.29	$54.65	$59.80	$109.36
50-54	$41.08	$80.04	$84.91	$165.64	$45.04	$84.00	$89.82	$170.54
55-59	$59.95	$117.62	$124.43	$244.36	$63.91	$121.57	$129.34	$249.26
60-64	$91.88	$181.23	$191.05	$377.12	$95.84	$185.19	$195.95	$382.02
65-69	$135.79	$268.79	$281.49	$557.50	$139.74	$272.75	$286.40	$562.41
70-74	$93.10	$183.33	$193.56	$381.43	$95.71	$185.94	$196.79	$384.66
75-79	$110.99	$219.32	$230.66	$465.04	$113.59	$221.92	$233.89	$459.27

☐ **I am a non-smoker.** ☐ **I am a smoker.**

☐ **Yes, I wish to enroll for Critical Illness insurance.**

$_______________ Employee Critical Illness Amount

$_______________ Spouse Critical Illness Amount

$_______________ Child(ren) Critical Illness Amount

☐ **No, I do not wish to enroll for Critical Illness insurance.**

Section 12: Flexible Spending Account (FSA) *ProBenefits*

Pre-tax medical and dependent care spending accounts are available for eligible out-of pocket expenses. You can roll over up to $500 of your 2016 FSA funds into 2017. For all reimbursement options, you are responsible for submitting appropriate documentation and receipts for verification under IRS guidelines.

☐ I decline to participate in both the Health Care and Dependent Care Flex Spending Accounts.

☐ I elect to participate in the Health Care and/or Dependent Care Flex Spending Accounts as indicated below.

Health Care FSA: (Minimum Election $0 / Maximum Election $2600.00)

$________________ Divided by 12 pay periods = $___________ per paycheck
(Total Annual Election)

Dependent Care FSA: (Minimum Election $0 / Maximum Election $5000.00 per household)

$________________ Divided by 12 pay periods = $___________ per paycheck
(Total Annual Election)

Section 13: Authorization

I authorize Pfeiffer University to deduct premiums for the benefits that I have elected above. I understand that these benefit elections may not be changed or cancelled until the next open enrollment period, unless I have a change in status as defined by IRS Rules. I also understand that if I experience a qualifying change in status, it is my responsibility to notify Pfeiffer University within 30 days of such a change.

Printed Name: ______________________________________

Employee Signature: ______________________________________ **Date:** ____________________

The information on this form is presented for illustrative purposes and is based on information provided by the employer. The text contained on this form was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the form and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this form, contact Human Resources.