2024-2025 BENEFITS ENROLLMENT FORM

DURAND, INC.
Est.1972

If you are choosing any of the plans below, you are hereby agreeing to pay for the coverage in the amount specified for each pay period, through salary deduction for benefits that are elected.

Effective Date: _____

A. EMPLOYEE INFORMATION (PLEASE PRINT)

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

Street Address	City	State	Zip

Home Phone	Work Phone				Date of Hire
		☐ Male ☐ Female	☐ Married ☐ Single	☐ Divorced ☐ Separated	/ /

B. MEDICAL/RX /VISION PLAN OPTION *(Select coverage tier AND plan)*

	CIGNA HSA OPEN ACCESS	CIGNA OPEN ACCESS PLUS
Single	☐ $35.00	☐ $80.00
Employee + Child(ren)	☐ $95.00	☐ $162.88
Employee + Spouse	☐ $155.00	☐ $226.74
Family	☐ $195.00	☐ $311.50
☐ WAIVE MEDICAL/RX/VISION BENEFITS		

C. DENTAL PLAN OPTION

PPO PLAN	
Single	☐ $14.00
Employee + Child(ren)	☐ $28.00
Employee + Spouse	☐ $20.00
Family	☐ $30.00
☐ WAIVE DENTAL BENEFITS	

E. DEPENDENT INFORMATION (Indicate dependents that you want covered by your medical, dental or vision plans)

LAST NAME, FIRST NAME, MI	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	COVERAGE
Spouse	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision

If enrolling more than four dependent children, please attach a separate sheet of paper with the above information.

F. ADDITIONAL VOLUNTARY BENEFIT OPTIONS

Section 125 Pre-Tax Savings Plan	☐ Medical Spending Plan $ _____ Annual Amount	☐ Dependent Care Spending Plan $ _____ Annual Amount	☐ **WAIVE** Savings Plan
Supplemental Life - Employee	$ _____ Employee Supplemental Life Amount		
Supplemental Life - Spouse/Child	$ _____ Spouse/Child Supplemental Life Amount		
Aflac Plan ☐ Accident ☐ Cancer ☐ Hospital	$ _____ Total Aflac Amount		
TOTAL COST	$ _____ TOTAL		

I apply for coverage, as indicated, for which I am or may become eligible through my employment with Durand, Inc. I have read the above statements and represent they are true to the best of my knowledge. If applicable, the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I authorize my employer to deduct from my pay the necessary premiums (if any) to be withheld through payroll deduction and, where allowed, on a pre-tax basis, in equal installments throughout the plan year.

I acknowledge that my election is irrevocable unless there is a change in my family status (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child, or termination of my spouse's employment).

Should I incur a Life Event and wish to make a change as a result of the Life Event, I understand that I am required to submit an Enrollment Form within 31 days of the Life Event and that coverage may be subject to a Pre-Existing Condition exclusion or limitation.

WAIVER OF INSURANCE

I _____, hereby certify that the insurance plans offered by Durand, Inc., have been explained and offered to me. However, by my own free will and without coercion, I have decided to waive my enrollment and refuse insurance coverage for myself and my eligible dependents. I further understand that should I want to enroll myself or my eligible dependents for medical and dental coverage in the future, I and/or my eligible dependents will be required to submit proof of coverage loss through another insurance carrier (in certain circumstances). If documentation is not submitted within 30 days of loss of coverage, enrollment requests will only be accepted during annual open enrollment each year.

EMPLOYEE SIGNATURE

Signature Date

<u>Both pages</u> of the form must be completed and returned to Rosemary Smith by email at r.smith@durandac.org

EMPLOYER VERIFICATION (To be completed by employer. Employer signature required.)

Signature Date

Effective Date