



# BENEFITS ENROLLMENT FORM

JANUARY 1, 2026 THROUGH DECEMBER 31, 2026

## 1. EMPLOYEE INFORMATION

|   |                             |                    |
|---|-----------------------------|--------------------|
| Name (please print):  |                             | Social Security #: |
| Address:  | Date of Birth (MM/DD/YYYY): | Date of Hire:      |
| City:   | State:                      | ZIP:               |
| Phone Number:   | Email Address:              |                    |
| Event: <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Life Event (QLE) | Gender:                     | Marital Status:    |
| Date of Hire or QLE: _____  |                             |                    |

## 2. MEDICAL PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

| Bi-Weekly Salary  |                       | OAMC HDHP WITH HSA                | EPO                               |
|-------------------|-----------------------|-----------------------------------|-----------------------------------|
| Less than \$1,000 | Employee Only         | <input type="checkbox"/> \$61.00  | <input type="checkbox"/> \$84.00  |
|                   | Employee + Child(ren) | <input type="checkbox"/> \$89.00  | <input type="checkbox"/> \$124.00 |
|                   | Employee + Spouse     | <input type="checkbox"/> \$116.00 | <input type="checkbox"/> \$162.00 |
|                   | Employee + Family     | <input type="checkbox"/> \$157.00 | <input type="checkbox"/> \$219.00 |
| \$1,000 – \$2,000 | Employee Only         | <input type="checkbox"/> \$81.00  | <input type="checkbox"/> \$134.00 |
|                   | Employee + Child(ren) | <input type="checkbox"/> \$119.00 | <input type="checkbox"/> \$197.00 |
|                   | Employee + Spouse     | <input type="checkbox"/> \$155.00 | <input type="checkbox"/> \$257.00 |
|                   | Employee + Family     | <input type="checkbox"/> \$210.00 | <input type="checkbox"/> \$348.00 |
| \$2,000 – \$4,000 | Employee Only         | <input type="checkbox"/> \$102.00 | <input type="checkbox"/> \$184.00 |
|                   | Employee + Child(ren) | <input type="checkbox"/> \$149.00 | <input type="checkbox"/> \$270.00 |
|                   | Employee + Spouse     | <input type="checkbox"/> \$194.00 | <input type="checkbox"/> \$353.00 |
|                   | Employee + Family     | <input type="checkbox"/> \$262.00 | <input type="checkbox"/> \$477.00 |
| \$4,000 – \$8,000 | Employee Only         | <input type="checkbox"/> \$122.00 | <input type="checkbox"/> \$233.00 |
|                   | Employee + Child(ren) | <input type="checkbox"/> \$178.00 | <input type="checkbox"/> \$344.00 |
|                   | Employee + Spouse     | <input type="checkbox"/> \$233.00 | <input type="checkbox"/> \$448.00 |
|                   | Employee + Family     | <input type="checkbox"/> \$315.00 | <input type="checkbox"/> \$605.00 |
| \$8,000+          | Employee Only         | <input type="checkbox"/> \$183.00 | <input type="checkbox"/> \$273.00 |
|                   | Employee + Child(ren) | <input type="checkbox"/> \$268.00 | <input type="checkbox"/> \$402.00 |
|                   | Employee + Spouse     | <input type="checkbox"/> \$349.00 | <input type="checkbox"/> \$524.00 |
|                   | Employee + Family     | <input type="checkbox"/> \$472.00 | <input type="checkbox"/> \$708.00 |

WAIVE MEDICAL COVERAGE

### 3. HEALTH SAVINGS ACCOUNT—INSPIRA

If you elect to participate in the Aetna OAMC HDHP Plan, you may contribute funds to an HSA on a pre-tax basis. The annual HSA contribution maximums are **\$4,400 for Employee Only Coverage** and **\$8,750 for all other coverage levels**. If you are age 55 or older, you may contribute an additional **\$1,000** (regardless of the coverage level you elected).

If you are interested in participating in an HSA, please check the box below and list your annual and per-pay contribution amounts.

**YES**, I would like to participate in the Health Savings Account through Inspira

My **ANNUAL** Contribution: \_\_\_\_\_

My **PER - PAY** Contribution: \_\_\_\_\_

### 4. DENTAL PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

|                       | DPPO                             | DHMO                             |
|-----------------------|----------------------------------|----------------------------------|
| Employee Only         | <input type="checkbox"/> \$18.78 | <input type="checkbox"/> \$5.04  |
| Employee + Child(ren) | <input type="checkbox"/> \$39.20 | <input type="checkbox"/> \$17.62 |
| Employee + Spouse     | <input type="checkbox"/> \$39.03 | <input type="checkbox"/> \$17.62 |
| Family                | <input type="checkbox"/> \$63.13 | <input type="checkbox"/> \$17.62 |

**WAIVE DENTAL COVERAGE**

### 5. VISION PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Aetna Vision Plan

|                                |                                  |
|--------------------------------|----------------------------------|
| Employee Only                  | <input type="checkbox"/> \$3.93  |
| Employee + Children            | <input type="checkbox"/> \$7.86  |
| Employee + 1 (Spouse or Child) | <input type="checkbox"/> \$7.47  |
| Family                         | <input type="checkbox"/> \$11.56 |

**WAIVE VISION COVERAGE**

### 6. DEPENDENT ENROLLMENT INFORMATION (ALL FIELDS REQUIRED)

| Dependent First & Last Name | Gender (M/F) | Relationship<br>(Spouse, DP, Child) | Date of Birth<br>(MM/DD/YYYY) | Social Security # | Add/Cancel Coverage   | Select Plan(s)<br>to Add/Cancel  |
|-----------------------------|--------------|-------------------------------------|-------------------------------|-------------------|---|--|
|                             |              |                                     |                               |                   | <input type="checkbox"/> Add<br><input type="checkbox"/> Cancel | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Vol Life & AD&D |
|                             |              |                                     |                               |                   | <input type="checkbox"/> Add<br><input type="checkbox"/> Cancel | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Vol Life & AD&D |
|                             |              |                                     |                               |                   | <input type="checkbox"/> Add<br><input type="checkbox"/> Cancel | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Vol Life & AD&D |
|                             |              |                                     |                               |                   | <input type="checkbox"/> Add<br><input type="checkbox"/> Cancel | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Vol Life & AD&D |
|                             |              |                                     |                               |                   | <input type="checkbox"/> Add<br><input type="checkbox"/> Cancel | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Vol Life & AD&D |

## 7. FLEXIBLE SPENDING ACCOUNTS (FSA)

**Please note:** If you are participating in the HSA, you may not enroll in the HealthCare FSA as both accounts pay similar expenses.

**NO**, I do not wish to participate in the Flexible Spending Accounts.

**YES**, I elect to participate in the following Flexible Spending Accounts:

**HEALTHCARE FSA** (out-of-pocket medical, dental and vision expenses for you and your dependents)

**Maximum Election: \$3,400**

**ACTION REQUIRED:** To enroll in the Flexible Spending Account(s), you must enroll by going to your Paychex Flex dashboard where you enter your hours in Time & Attendance. Once there click on the "PBA Benefits Account" tab. On this tab, you can update your current enrollment or you can enroll through there by clicking on "Enroll Now"

**DEPENDENT CARE FSA** (out-of-pocket day care expenses)

**Minimum Election: \$250.00**

**Maximum Election: \$7,500** (Single/Married Filing Jointly)  
**\$3,750** (Married Filing Separately)

**ACTION REQUIRED:** To enroll in the Flexible Spending Account(s), you must enroll by going to your Paychex Flex dashboard where you enter your hours in Time & Attendance. Once there click on the "PBA Benefits Account" tab. On this tab, you can update your current enrollment or you can enroll through there by clicking on "Enroll Now"

**PARKING - Maximum Election: \$340 per month**

**TRANSIT - Maximum Election: \$340 per month**

Monthly Election:

Monthly Election:

## 8. BASIC LIFE/ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AND LONG-TERM DISABILITY (LTD)

Windmill offers our employees Basic Life and AD&D Insurance and Long-Term Disability Insurance. **Windmill pays 100% of the premium for both of these benefits and enrollment is automatic.**

*Please indicate your beneficiary designation for your Life Insurance benefits in the event of your death. You may indicate a Primary and Contingent Beneficiary. You may also name more than one Primary and/or Contingent Beneficiary. Unless designated otherwise, payment will be made in equal shares or all to the survivor. You have the right to change this beneficiary designation at any time.*

| Beneficiary Type                                      | Beneficiary Name | Beneficiary Address | Date of Birth | SSN | Relationship | % of Benefit |
|---|------------------|---------------------|---------------|-----|--------------|--------------|
| <input type="checkbox"/> P <input type="checkbox"/> C |                  |                     |               |     |              |              |
| <input type="checkbox"/> P <input type="checkbox"/> C |                  |                     |               |     |              |              |
| <input type="checkbox"/> P <input type="checkbox"/> C |                  |                     |               |     |              |              |
| <input type="checkbox"/> P <input type="checkbox"/> C |                  |                     |               |     |              |              |
| <input type="checkbox"/> P <input type="checkbox"/> C |                  |                     |               |     |              |              |
| <input type="checkbox"/> P <input type="checkbox"/> C |                  |                     |               |     |              |              |

## 9. EMPLOYEE VOLUNTARY LIFE AND AD&D—LINCOLN FINANCIAL

### Employee Election:

- Minimum election: **\$10,000**
- Maximum election: **\$500,000**
- Guaranteed issue: **\$300,000**

Elect coverage amount: \$ \_\_\_\_\_

Waive Coverage

### Calculation for biweekly, weekly, and semimonthly rates:

- Biweekly = Monthly rate multiplied by 12 and divided by 26.
- Weekly [52] = Monthly rate multiplied by 12 and divided by 52.
- Weekly [48] = Monthly rate multiplied by 12 and divided by 78.
- Semimonthly = Monthly rate multiplied by 12 and divided by 24.

**You will be REQUIRED to complete the Evidence of Insurability (EOI) form if you elect more than the Guarantee Issue amount for yourself if you are electing coverage after your initial eligibility period. Completion of this form does not guarantee the Voluntary Life amount**

**Step 1:** Determine your monthly rate that corresponds with you or your spouse's age.

**Step 2:** Determine your desired coverage benefit amount in dollars.

**Step 3:** Divide the coverage benefit amount by \$1,000, then multiply by your monthly rate to calculate your monthly premium cost.

### Spouse Election:

- Minimum election: **\$5,000**
- Maximum election: **\$250,000**
- Guaranteed issue: **\$30,000**

Elect coverage amount: \$ \_\_\_\_\_

Waive Coverage

### Child(ren) Election:

- Minimum election: **\$1,000**
- Maximum election: **\$10,000**
- Guaranteed issue: **\$10,000**

Elect coverage amount: \$ \_\_\_\_\_

Waive Coverage

**REQUIRED to complete the Evidence of Insurability (EOI) form if you elect more than the Guaranteed Issue amount for yourself if you are electing coverage after your initial eligibility period. Completion of this form does not guarantee the Voluntary Life amount requested will be approved.**

**SEE PAGE 6 FOR VOLUNTARY LIFE/AD&D RATE INFORMATION**

## 10. VOLUNTARY SHORT-TERM DISABILITY—LINCOLN FINANCIAL

Please check (✓) one box

**Elect** STD Coverage     **Waive** STD Coverage

**Step 1:** Determine your monthly rate per \$10 of weekly benefit.

**Step 2:** Determine your maximum weekly covered earnings. Divide your annual earnings by 52 to calculate your weekly earnings. If your weekly earnings exceed the maximum weekly covered earnings, your premium will be based off of the maximum weekly covered earnings amount.

**Step 3:** Multiply weekly covered earnings by the maximum benefit percentage to calculate your weekly benefit. For example, if the percentage is 60%, use 0.60 in the calculation.

**Step 4:** Is your benefit based on an incremental plan? No, skip to Step 5.

If yes, determine your benefit election amount in increments (not to exceed the maximum benefit or the maximum weekly covered earnings calculated in Step 3).

**Step 5:**

Divide the weekly benefit in Step 3 by \$10, then multiply by your monthly rate to calculate your monthly premium cost.

**SEE PAGE 6 FOR VOLUNTARY SHORT-TERM DISABILITY RATE INFORMATION**

## EMPLOYEE AUTHORIZATION

*I hereby acknowledge that I cannot change my elections during the Plan Year, unless there is a change in family status, under the terms of the Plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through Windmill Health Products during the open enrollment period each year and during the year within 30 days of a qualified change in status.*

*By enrolling in medical, dental, vision and/or flexible spending account coverage, I am authorizing Windmill to take the necessary contributions from my salary for the benefits in which I have enrolled on a **BEFORE-TAX** basis. I understand benefits choices will be irrevocable (with the exception of the transit account) for the coming Plan Year unless I have a change in family status or elect to have my contributions taken from my pay on an **AFTER-TAX BASIS**. Prior to December 31 of each year, I will be offered the opportunity to elect coverage for the following Plan Year. If I do not complete and return a new Benefit Election Form at that time, I will be treated as having elected to continue all before tax benefits under the Plan for the following Plan Year, with the exception of Flexible Spending Accounts (Health and Dependent Care) and Health Savings Accounts. I further understand Healthcare and Dependent Care Account elections do not roll over and must be elected each Plan Year.*

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## VOLUNTARY LIFE/AD&D RATE INFORMATION

### Option

**Employee Life/AD&D** \$0.025 per \$1,000 in covered benefit

**Spouse Life/AD&D** \$0.025 per \$1,000 in covered benefit

**Child(ren) Life Insurance** \$0.160 per \$1,000 in covered benefit

### EMPLOYEE & SPOUSE LIFE INSURANCE MONTHLY RATE

| Age Range    | Premium monthly rate per \$1,000 |
|--------------|----------------------------------|
| <b>1-29</b>  | \$0.070                          |
| <b>30-34</b> | \$0.080                          |
| <b>35-39</b> | \$0.110                          |
| <b>40-44</b> | \$0.290                          |
| <b>45-49</b> | \$0.440                          |
| <b>50-54</b> | \$0.759                          |
| <b>55-59</b> | \$1.249                          |
| <b>60-64</b> | \$2.009                          |
| <b>65-69</b> | \$3.208                          |
| <b>70-74</b> | \$5.456                          |
| <b>75-79</b> | \$12.131                         |
| <b>80-84</b> | \$16.378                         |
| <b>85-89</b> | \$20.945                         |
| <b>90+</b>   | \$26.731                         |

### VOLUNTARY SHORT-TERM DISABILITY RATE INFORMATION

| Age Range    | Premium monthly rate per \$10 |
|--------------|-------------------------------|
| <b>0-39</b>  | \$0.416                       |
| <b>40-44</b> | \$0.434                       |
| <b>45-49</b> | \$0.446                       |
| <b>50-54</b> | \$0.454                       |
| <b>55-59</b> | \$0.465                       |
| <b>60-64</b> | \$0.504                       |
| <b>65-69</b> | \$0.522                       |
| <b>70+</b>   | \$0.543                       |