WINDMILL™ HEALTH PRODUCTS

BENEFITS ENROLLMENT FORM

JANUARY 1, 2025 THROUGH DECEMBER 31, 2025

1. EMPLOYEE INFORMATION

Name (please print):	Employee ID Number:	Social Security #:
Address:	Date of Birth (MM/DD/YYYY):	Date of Hire:
City:	State:	ZIP:
Phone Number:	Email Address:	
Event: ☐ New Hire ☐ Qualifying Life Event (QLE) Date of Hire or QLE: _____	Gender:	Marital Status:

2. MEDICAL PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

Bi-Weekly Salary		OAMC HDHP WITH HSA	LOW EPO	HIGH EPO
Less than $1,000	**Employee Only**	☐ $61.00	☐ $84.00	☐ $87.00
	Employee + Child(ren)	☐ $89.00	☐ $124.00	☐ $129.00
	Employee + Spouse	☐ $116.00	☐ $162.00	☐ $168.00
	Employee + Family	☐ $157.00	☐ $219.00	☐ $228.00
$1,000 – $2,000	**Employee Only**	☐ $81.00	☐ $134.00	☐ $139.00
	Employee + Child(ren)	☐ $119.00	☐ $197.00	☐ $205.00
	Employee + Spouse	☐ $155.00	☐ $257.00	☐ $267.00
	Employee + Family	☐ $210.00	☐ $348.00	☐ $362.00
$2,000 – $4,000	**Employee Only**	☐ $102.00	☐ $184.00	☐ $191.00
	Employee + Child(ren)	☐ $149.00	☐ $270.00	☐ $281.00
	Employee + Spouse	☐ $194.00	☐ $353.00	☐ $367.00
	Employee + Family	☐ $262.00	☐ $477.00	☐ $496.00
$4,000 – $8,000	**Employee Only**	☐ $122.00	☐ $233.00	☐ $242.00
	Employee + Child(ren)	☐ $178.00	☐ $344.00	☐ $357.00
	Employee + Spouse	☐ $233.00	☐ $448.00	☐ $465.00
	Employee + Family	☐ $315.00	☐ $605.00	☐ $629.00
$8,000+	**Employee Only**	☐ $183.00	☐ $273.00	☐ $284.00
	Employee + Child(ren)	☐ $268.00	☐ $402.00	☐ $418.00
	Employee + Spouse	☐ $349.00	☐ $524.00	☐ $544.00
	Employee + Family	☐ $472.00	☐ $708.00	☐ $736.00

☐ **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 **$4,300 for Employee Only Coverage** and **$8,550 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	☐ $18.78	☐ $5.04
Employee + Child(ren)	☐ $39.20	☐ $17.62
Employee + Spouse	☐ $39.03	☐ $17.62
Family	☐ $63.13	☐ $17.62

☐ **WAIVE DENTAL COVERAGE**

5. VISION PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

	Aetna Vision Plan
Employee Only	☐ $3.93
Employee + Children	☐ $7.86
Employee + 1 (Spouse or Child)	☐ $7.47
Family	☐ $11.56

☐ **WAIVE VISION COVERAGE**

6. DEPENDENT ENROLLMENT INFORMATION (ALL FIELDS REQUIRED)

Dependent First & Last Name	Gender (M/F)	Relationship (Spouse, DP, Child)	Date of Birth (MM/DD/YYYY)	Social Security #	Add/Cancel Coverage	Select Plan(s) to Add/Cancel
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision

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: $3,300

Amount Per Pay Period: _____ x ___ Pay Periods = Annual Election: _____

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

Minimum Election: $250.00

Maximum Election: $5,000 (Single/Married Filing Jointly)
$2,500 (Married Filing Separately)

Amount Per Pay Period: _____ x ___ Pay Periods = Annual Election: _____

☐ **PARKING - Maximum Election: $325 per month**

Monthly Election: _____

☐ **TRANSIT - Maximum Election: $325 per month**

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
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						

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: _____