WINDMILL™ HEALTH PRODUCTS

BENEFITS ENROLLMENT FORM

JANUARY 1, 2024 THROUGH DECEMBER 31, 2024

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

Weekly Salary		EPO	OMNIA
< $500/week	**Employee Only**	☐ $84	☐ $61
	Employee + Spouse	☐ $162	☐ $116
	Employee + Child(ren)	☐ $124	☐ $89
	Employee + Family	☐ $219	☐ $157
$500-$1,000/week	**Employee Only**	☐ $134	☐ $81
	Employee + Spouse	☐ $257	☐ $155
	Employee + Child(ren)	☐ $197	☐ $119
	Employee + Family	☐ $348	☐ $210
$1,000-$2,000/week	**Employee Only**	☐ $184	☐ $102
	Employee + Spouse	☐ $353	☐ $194
	Employee + Child(ren)	☐ $270	☐ $149
	Employee + Family	☐ $477	☐ $262
$2,000-$4,000/week	**Employee Only**	☐ $233	☐ $122
	Employee + Spouse	☐ $448	☐ $233
	Employee + Child(ren)	☐ $344	☐ $178
	Employee + Family	☐ $605	☐ $315
$4,000+/week	**Employee Only**	☐ $273	☐ $183
	Employee + Spouse	☐ $524	☐ $349
	Employee + Child(ren)	☐ $402	☐ $268
	Employee + Family	☐ $708	☐ $472

☐ **WAIVE MEDICAL COVERAGE**

3. DENTAL PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	DHMO Plan	PPO Plan
Employee Only	☐ $5.66	☐ $17.27
Employee + Spouse	☐ $19.80	☐ $35.88
Employee + Child(ren)	☐ $19.80	☐ $36.04
Employee + Family	☐ $19.80	☐ $58.03

REQUIRED FOR DMO PLAN: If you choose to enroll in the DHMO plan, you will need to select a provider. To find an in network provider, please go to www.dentaldentalins.com/deltacare and use the **DeltaCare USA** network or call 800-422-4234. Please indicate the provider's facility number:

☐ **WAIVE VISION COVERAGE**

4. VISION PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	Low Plan	High Plan
Employee Only	☐ $4.60	☐ $6.19
Employee + 1 (Spouse or Child)	☐ $7.35	☐ $9.91
Employee + Children	☐ $7.51	☐ $10.12
Employee + Family	☐ $12.10	☐ $16.32

☐ **WAIVE VISION COVERAGE**

5. 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

6. FLEXIBLE SPENDING ACCOUNTS (FSA)

☐ **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: $3,200

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: $315 per month**

_____

☐ **TRANSIT - Maximum Election: $315 per month**

_____

7. 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: _____