

**LHK PARTNERS, INC.** Plan Year 11-1-2019 to 10-31-2020 Benefit Election Form - CORPORATE

**A. General Employee Information**

Last Name	First Name	Date of Birth	Social Security Number

**B. Health Care Benefit Costs Per First Two Biweekly Pays of Each Month**  
**ADDRESS ALL OPTIONS BELOW**

**Cigna Medical Plan Option (check one):**

Enrollment in coverage for:

- Employee Only - \$93.28
- Employee + Child(ren) - \$166.34
- Employee + Spouse, \$214.65
- Employee + Spouse, including spousal surcharge - \$244.65
- Family - \$273.70
- Family, including spousal surcharge- \$303.70

Waive\* - I do not elect coverage.

*\*Please explain reason for waiving medical coverage, include carrier name:*

**MetLife Dental Plan Option (check one):**

Enrollment in coverage for:

- Employee Only - \$7.10
- Employee + Child(ren) - \$16.99
- Employee +Spouse - \$14.54
- Family - \$24.44

Waive\* - I do not elect coverage.

*\*Please explain reason for waiving dental coverage, include carrier name:*

**MetLife Vision Plan Option (check one):**

Enrollment in coverage for:

- Employee Only - \$1.13
- Employee + Child(ren) - \$1.92
- Employee +Spouse - \$2.27
- Family - \$3.17

Waive\* - I do not elect coverage.

*\*Please explain reason for waiving vision coverage, include carrier name:*

**C. Pre-Tax Election**

I elect to defer the amount selected above in Section B from my pay.

I hereby make the above benefit elections for the Plan Year 2019-2020. I authorize my employer to deduct from my pay the amounts listed to pay my portion of costs for myself and/or my dependents. I understand that coverage will not be effective until I complete all necessary enrollment forms for my above selected plans. I understand that I cannot change or revoke any pre-tax election until open enrollment 2020-2021 unless I have a qualifying change in family status such as: marriage, divorce, death of spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or part-time to full-time, my spouse or I taking an unpaid leave of absence, and such other events as a plan administrator determines will permit a change or a revocation of an election (LIFE EVENT CHANGES MUST BE SUBMITTED WITHIN 30 DAYS OF THE EVENT). I understand that by participating in the Pre-Tax Plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. Prior to each plan year, I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, my failure to respond in a timely manner will mean that I chose to waive all coverage options.

Signature

Date