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

A. General Employee Information

Last Name	First Name	Date of Birth	Social Security Number

B. Health Care Benefit Costs Per First Four Pays of Each Month

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

Enrollment in coverage for:

- ❑ **Employee only - $46.64 deducted each of the first four weekly pays of the month**
- ❑ **Employee + Child(ren) - $83.17 deducted each of the first four weekly pays of the month**

As an employee of variable pay, I understand that my monthly deduction amount of $186.56 for employee only coverage or $332.68 for employee + child(ren) coverage is to be spread over the first four weekly pays of the month. If I have not fully paid my portion of costs due in any one of the first three weekly pays of the month, the remaining monthly deduction is to be pro-rated over any remaining pays. The deduction will be taken on a fifth pay of the month, if applicable, only if premiums were not fully paid on the fourth weekly pay of the month. If I did not fully pay my portion of costs due by the last weekly pay of the month, I must immediately submit the outstanding amount to LHK Partners, Inc. or be subject to cancellation of coverage.

- ❑ **Waive* - I do not elect coverage.**
  **Please explain reason for waiving medical 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