INFRAMARK

2021 BENEFITS ENROLLMENT

(Bridgeport, Connecticut Only)

Plan Year Start Date: January 1, 2021
Plan Year End Date: December 31, 2021

Enrollment Type: (Check One) ☐ New Enrollment ☐ Change due to a Qualifying Life Event (QLE)

Date of Hire: _____

Effective Date: _____

If you checked "Change due to a Qualifying Life Event (QLE)", please provide the type of QLE and the date associated with the event. Supporting documentation for the QLE is required. If you are enrolling a dependent in coverage, you are required to submit verification of your dependent's eligibility (marriage certificate, birth certificate etc.). The change WILL NOT be processed until the documentation is received and approved.

Type of QLE: _____ **Date of QLE:** _____

INSTRUCTIONS

Your benefit options are identified in the following sections. Please review your options carefully, then indicate your selections in each section that applies. Once you are finished making your benefit elections, you may fax your completed enrollment form to the Employee Benefits Service Center at **866-406-6946**, **OR** return your form to your Human Resources representative. If you have any questions or require assistance, please call the Benefits InfoLine at **866-545-3756**.

EMPLOYEE PROFILE

Name: _____ **Effective Date:** _____

Address: _____ **SSN:** _____ – _____ – _____

City, State and Zip: _____ **Date of Birth:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) **Sex:** ☐ Male ☐ Female

Phone # / Email: _____

FLEXIBLE SPENDING ACCOUNTS

$130 ANNUAL MINIMUM/$2,750 HEALTH & $5,000 DEPENDENT CARE ANNUAL MAXIMUMS (PRE-TAX)

To elect a Health Care and/or Dependent Care Flexible Spending Account (FSA), please indicate below the **annual amount** that you would like to contribute to your account (NOTE: this annual amount will be divided among the number of pay periods in the calendar year to determine your contribution per pay period). Please review the FSA section of your Guidebook carefully before enrolling.

☐ **YES**, I would like to elect a Health Care FSA. MY ANNUAL CONTRIBUTION AMOUNT is $_____.

☐ **YES**, I would like to elect a Dependent Care FSA ***(see below)***. MY ANNUAL CONTRIBUTION AMOUNT is $_____.

☐ **WAIVE HEALTH CARE FSA BENEFITS** / ☐ **WAIVE DEPENDENT CARE FSA BENEFITS**

Please Note: A Dependent Care FSA is **NOT** for health care expenses for your dependents. Please refer to page 17 of your Guidebook for more details.

SUPPLEMENTAL LIFE INSURANCE (AFTER-TAX, **SEE NEXT PAGE FOR RATES)**

EMPLOYEE COVERAGE ELECTION: ☐ 1 times salary ☐ 2 times salary ☐ 3 times salary ☐ 4 times salary ☐ 5 times salary

☐ **WAIVE EMPLOYEE COVERAGE**

SPOUSE COVERAGE ELECTION: ☐ $10,000 ☐ $20,000 ☐ $30,000* ☐ $40,000* ☐ $50,000* ☐ **WAIVE SPOUSE COVERAGE**

These amounts will require your spouse to complete an Evidence of Insurability questionnaire.

DEPENDENT CHILD(REN) COVERAGE ELECTION: ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ **WAIVE DEPENDENT CHILD(REN) COVERAGE**

LIFE INSURANCE BENEFICIARY INFORMATION

ALL EMPLOYEES MUST COMPLETE THIS SECTION. Please name the beneficiary(ies) for your Company-Paid and Supplemental Life Insurance (if applicable) benefits.

Beneficiary Name (First, MI, Last)	Type (Primary or Contingency)	Date of Birth	SSN	Relationship	Percentage of Benefit (Combined Total Must = 100%)

FORM CONTINUES ON BACK/NEXT PAGE

Inframark 2020 ENROLLMENT FORM – NAME: _____

LONG-TERM DISABILITY COVERAGE

☐ **Tax me later** – Pay no taxes now on the value of your LTD coverage; then pay taxes only if you collect an LTD benefit in the future.

☐ **Tax me now (Default) –** Pay taxes now on the value of the LTD premium paid by Inframark. If you elect this option, additional taxes will be withheld from each pay check to cover the expected tax on the value of the coverage. You would then pay no taxes if you collect an LTD benefit in the future.

LEGAL SERVICES (AFTER-TAX)

☐ **YES**, I would like to elect **Hyatt Legal Plan** at a per pay cost of $3.70 ☐ **WAIVE LEGAL COVERAGE**

LIFELOCK NORTON BENEFITS (AFTER-TAX)

☐ **YES**, I would like to elect **LifeLock Norton** benefits at the coverage level indicated below:

COVERAGE LEVEL	**LifeLock Norton Benefit Essential**	**LifeLock Norton Benefit Premier**
Employee Only *(age 18+)*	☐ $1.96	☐ $3.46
Employee & Family	☐ $3.92	☐ $6.92
☐ **WAIVE LIFELOCK BENEFITS**		

YOUR PHONE: _____

YOUR EMAIL: _____

AUTHORIZATION

I have been provided with information relating to each of the above benefit options. I have reviewed this information and understand it. I authorize Inframark to reduce my salary by the agreed upon amounts indicated on this form to pay premiums for myself and/or my dependents on a pre-tax basis for the pre-tax coverages I selected above. These plan elections will stay in effect through December 31, 2020 unless I experience a qualified family status change (and notify Human Resources or the Benefits InfoLine within 31 days of the event) or my employer changes the plan or the duration of the plan year, whichever comes first. I understand the benefit options and costs presented here are based on my current benefit eligibility, salary and age as of effective date and that the benefits and costs will be adjusted based on any changes in eligibility, salary and/or age.

Employee Signature _____ **Date** _____

SUPPLEMENTAL LIFE INSURANCE

You may purchase Supplemental Term Life Insurance for yourself, your spouse, and your children. If you elect this coverage, you are responsible for paying 100% of the benefit cost.

Employee Supplemental Life Insurance lets you purchase coverage of 1 to 5 times your salary, up to a maximum of $500,000. Evidence of insurability is required for a mounts over $250,000.

Spouse Supplemental Life Insurance lets you purchase coverage for $10,000, $20,000, $30,000, $40,000, or a maximum of $50,000. Evidence of insurability is required for amounts over $20,000.

Child Supplemental Life Insurance lets you purchase coverage for $2,500, $5,000, or $10,000. Your unmarried dependent children may be covered up to age 26.

Guaranteed Issue at Open Enrollment: Employees who already have some coverage in place may acquire additional coverage equivalent to 1x your salary at open enrollment this year, without providing Evidence of insurability (EOI). If spouse coverage is $10,000, an additional $10,000 can be elected without EOI. Those that have been previously denied by Lincoln are not eligible for the one-level benefit increase.

Supplemental Employee/Spouse Life Insurance Weekly Rates

Insured Age	**Weekly cost per $1,000 of coverage**
LT 25	$0.013
25-29	$0.016
30-34	$0.022
35-39	$0.024
40-44	$0.027
45-49	$0.041
50-54	$0.070
55-59	$0.130
60-64	$0.219
65-69	$0.343
70-74	$0.579
75+	$0.579

Dependent Life Insurance Weekly Rates

Dependent (Children) Coverage Amount	**Weekly cost per for all dependent children**
$2,500	$0.115
$5,000	$0.231
$10,000	$0.441