

EMPLOYEE ELECTION WORKSHEET

Montessori Children's House

Name: _____

Effective October 1, 2025 **Include personal info below:**

SS No. _____	Date of Birth: _____	Date of Hire: _____	Phone Number: _____
Gender: _____	Email Address: _____	Carrier Billed Monthly Amount	Employee Paid Monthly Portion
Street Address, City, State, Zip Code: _____		EE Per Pay Period (Bi-Weekly 26)	

Please Mark your Election in the BOX; for each Line of Coverage Below:

Blue Cross AR \$500 [BC 500-80_E_3] - Medical Plan					
Employee Only	<input type="checkbox"/>	\$	291.65	\$	58.33
Employee + Spouse	<input type="checkbox"/>	\$	697.98	\$	139.60
Employee + Children	<input type="checkbox"/>	\$	843.79	\$	168.76
Employee + Family	<input type="checkbox"/>	\$	1,383.61	\$	276.73
WAIVE COVERAGE	<input type="checkbox"/>				

All eligible full-time employees will receive these benefits after the required waiting period has been met. Benefits Include: (\$15k Basic Life/ADD; Short-Term Disability; and Long-Term Disability) coverage at NO COST to Employee. Please make sure to complete your beneficiary information on this form, and complete all required sections before submitting to HR.

DEPENDENT INFORMATION REQUIRED:

(Required if enrolling/changing dependents on the plans - Attach additional sheet if needed) Employee must be enrolled to cover dependents.

Spouse Name Gender: Female Male

Date of Birth

SSN

Child Name Gender: Female Male

Date of Birth

SSN

Child Name Gender: Female Male

Date of Birth

SSN

Child Name Gender: Female Male

Date of Birth

SSN

Child Name Gender: Female Male

Date of Birth

SSN

Delta Dental AR-Dental Plan

Employee Only	<input type="checkbox"/>	\$	30.44	\$	30.44
Employee + Spouse	<input type="checkbox"/>	\$	60.56	\$	60.56
Employee + Children	<input type="checkbox"/>	\$	66.39	\$	66.39
Employee + Family	<input type="checkbox"/>	\$	103.10	\$	103.10
WAIVE COVERAGE	<input type="checkbox"/>				

Delta Dental AR- Vision Plan

Employee Only	<input type="checkbox"/>	\$	9.09	\$	9.09
Employee + Spouse	<input type="checkbox"/>	\$	16.35	\$	16.35
Employee + Children	<input type="checkbox"/>	\$	17.72	\$	17.72
Employee + Family	<input type="checkbox"/>	\$	24.54	\$	24.54
WAIVE COVERAGE	<input type="checkbox"/>				

Lincoln Financial- Basic Life/AD&D Plan-\$15,000 coverage amount. (Employer Paid)

Employee Auto Enrolled when first eligible, after meeting required waiting period.

Lincoln Financial- Short-Term Disability Plan (Employer Paid)

Employee Auto Enrolled when first eligible, after meeting required waiting period.

Lincoln Financial- Long-Term Disability Plan (Employer Paid)

Employee Auto Enrolled when first eligible, after meeting required waiting period.

PLEASE VERIFY BENEFICIARY INFORMATION

Beneficiary Information:

Primary Beneficiary	Percentage	Relationship	Home Address	Gender	Date of Birth
Full Name:					

Contingent Beneficiary	Percentage	Relationship	Home Address	Gender	Date of Birth
Full Name:					

Contingent Beneficiary	Percentage	Relationship	Home Address	Gender	Date of Birth
Full Name:					

SEE OTHER SIDE FOR

Voluntary Benefits

Carrier Billed Employee Paid EE Per Pay Period
Monthly Amount Monthly Portion (Bi-Weekly 26)

Select Voluntary Plans Below:

Guardian - Accident (off job)

Employee Only	<input type="checkbox"/>	\$	12.81	\$	12.81	\$	5.91
Employee + Spouse	<input type="checkbox"/>	\$	21.40	\$	21.40	\$	9.88
Employee + Children	<input type="checkbox"/>	\$	22.52	\$	22.52	\$	10.39
Employee + Family	<input type="checkbox"/>	\$	31.11	\$	31.11	\$	14.36
WAIVE COVERAGE	<input type="checkbox"/>						

Guardian - Hospital (Plan 1) \$1000

Employee Only	<input type="checkbox"/>	\$	15.35	\$	15.35	\$	7.09
Employee + Spouse	<input type="checkbox"/>	\$	30.72	\$	30.72	\$	14.18
Employee + Children	<input type="checkbox"/>	\$	26.83	\$	26.83	\$	12.39
Employee + Family	<input type="checkbox"/>	\$	42.18	\$	42.18	\$	19.47
WAIVE COVERAGE	<input type="checkbox"/>						

Guardian - Critical Illness \$10k or 20k EE, \$5k or 10k SP. (Spouse 50% & Child 25% of EE amount)

<input type="checkbox"/> Employee-Enroll	<input type="checkbox"/> Spouse-Enroll	<input type="checkbox"/> Employee-Waive	<input type="checkbox"/> Spouse-Waive
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000		
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$10,000		

Monthly Rates	<30	30-39	40-49	50-59	60-69	70+
Employee						
10,000	\$5.40	\$9.60	\$19.00	\$37.60	\$63.80	\$101.10
20,000	\$10.80	\$19.20	\$38.00	\$75.20	\$127.60	\$202.20

Spouse	<30	30-39	40-49	50-59	60-69	70+
5,000	\$2.70	\$4.80	\$9.50	\$18.80	\$31.90	\$50.55
10,000	\$5.40	\$9.60	\$19.00	\$37.60	\$63.80	\$101.10

Lincoln Financial- Voluntary Life/AD&D

<input type="checkbox"/> Employee-Enroll	<input type="checkbox"/> Spouse-Enroll	<input type="checkbox"/> Employee-Waive Coverage
Increments of \$10,000	Increments of \$5,000	<input type="checkbox"/> Child Enroll (circle one amount below)
EE Max: \$500,000	SP Max: \$50,000	\$1,000 or \$10,000
EE GI: \$100,000	SP GI: \$20,000	Child age 6 months+ can elect \$10k.
\$ _____	\$ _____	

Monthly Rates per \$1,000 of coverage	Employee	Spouse
Age Range (spouse based on EE's age)		
0 - 24	\$0.044	\$0.044
25 - 29	\$0.054	\$0.054
30 - 34	\$0.071	\$0.071
35 - 39	\$0.080	\$0.080
40 - 44	\$0.089	\$0.089
45 - 49	\$0.132	\$0.132
50 - 54	\$0.204	\$0.204
55 - 59	\$0.379	\$0.379
60 - 64	\$0.583	\$0.583
65 - 69	\$1.122	\$1.122
70 +	\$1.820	\$1.820
Child Life Rate	\$0.250	
AD&D Rate (Employee / Spouse)	\$0.014 / \$0.014	

SECTION 125 DISCLAIMER, MUST READ AND RESPOND

I understand that the selection of benefits and the indication that a premium is to be paid does not necessarily include me in the insurance program. My election may require me to complete an application as well.

- I elect to enroll in the Premium-Only Plan and have my portion of eligible insurance premiums paid on a pre-tax and pre-FICA basis. I understand this could result in tax savings. This will not affect my coverage, timing of payment or level of any other benefit offered by the Company.
- I elect to NOT have my portion of the insurance premiums paid on a pre-tax and pre-FICA basis. I understand that this could result in a loss of tax savings that otherwise would be available to me.
- I have read the information provided to me pertaining to the Premium Only Plan and I understand that if I do NOT return this form to the Administrator prior to my eligibility date, my contributions for my eligible insurance premiums will be deducted from my pay on a post-tax basis.

By signing below, I confirm I choose to Enroll in the above selected benefit(s).

Signature

Employee Name (Print)

Date

WAIVER SECTION ONLY - Complete this section ONLY if Declining coverage. By signing below, I confirm that I choose to Decline coverage for myself and for eligible dependents for the selected benefit. (declined boxes must be marked under lines of coverage.)

Signature

Employee Name (Print)

Date

Please Note: If your employee account has been set up by your HR department in the "Employee Navigator" benefit admin enrollment portal, you can also log in and review your benefits package. Website link: <https://www.employeenavigator.com/>



Username

Password

Login

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