2022-2023 BENEFITS ENROLLMENT FORM

EMPLOYEE INFORMATION

Name: (Last, First, Middle Initial)		Social Security Number:		Date of Birth:	
Street Address:		City:		State:	Zip:
Phone Number:	Date of Hire:	Marital Status:	Gender:	Union: ☐ Yes ☐ No	
Email:		Work Location:			

MEDICAL & PRESCRIPTION INSURANCE

All rates are per pay period		Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
☐	Non-Union Employee Rate	☐ $0	☐ $0	☐ $0	☐ $0
☐	Union Employee Rate	☐ $11.26	☐ $11.26	☐ $11.26	☐ $11.26
☐	WAIVE COVERAGE (*Please check reason for declining*) ☐ SPOUSAL COVERAGE ☐ MEDICARE ☐ MEDICAID ☐ TRICARE ☐ OTHER COVERAGE ☐ DO NOT WANT **IMPORTANT:** The cancellation of Medical & Prescription Insurance will waive coverage until the next Open Enrollment period, which is October 1st, unless there is a Life Event that takes place				

VISION INSURANCE

Vision insurance is provided by Guardian through the Davis Vision network, offers both in-network and out-of-network coverage, and is included in the medical plan.

DENTAL INSURANCE

All Contribution rates are per pay period		Employee Only	Employee/Spouse	Employee/Child(ren)	Employee/Family
☐	Delta Dental	☐ $0	☐ $0	☐ $0	☐ $0
☐	WAIVE COVERAGE **IMPORTANT:** The cancellation of Dental Insurance will waive coverage until the next Open Enrollment period, which is October 1st, unless there is a Life Event that takes place				

HSI
HABERLE STEEL INC.

LACHER

DEPENDENT AND SPOUSE INFORMATION				
Spouse Name: (Last, First, Middle Initial)	Date of Birth:	Gender:	☐ Medical ☐ Dental ☐ Vision	Social Security Number:
Child Name: (Last, First, Middle Initial)	Date of Birth:	Gender:	☐ Medical ☐ Dental ☐ Vision	Social Security Number:
Child Name: (Last, First, Middle Initial)	Date of Birth:	Gender:	☐ Medical ☐ Dental ☐ Vision	Social Security Number:
Child Name: (Last, First, Middle Initial)	Date of Birth:	Gender:	☐ Medical ☐ Dental ☐ Vision	Social Security Number:
Child Name: (Last, First, Middle Initial)	Date of Birth:	Gender:	☐ Medical ☐ Dental ☐ Vision	Social Security Number:
Child Name: (Last, First, Middle Initial)	Date of Birth:	Gender:	☐ Medical ☐ Dental ☐ Vision	Social Security Number:

AUTHORIZATION AND SIGNATURE (sign and date)

- I understand that I cannot change any of these elections for medical, dental, and dependent coverage until the next open enrollment period, unless I have qualifying change in status.
- If I waived medical coverage, I certify that I have other medical coverage.
- **Payroll Deduction/Pretax Premium/Billing Agreement:** I authorize Haberle Steel, Inc. to deduct from my earnings the amount required to cover my share of the premium for these coverages. If I elect to participate in pretax health premiums, I authorize Haberle Steel, Inc. to reduce my taxable income by an amount equal to my health premiums. If I am being billed, I understand that failure to pay my premium(s) will result in cancellation of coverage.
- **Waiver Agreement**: After my initial enrollment period, I understand that in order to enroll in the future I may be required to provide evidence of insurability, and I may enroll in some plans only during open enrollment periods and/or be subject to pre-existing condition limitations.
- **Release of Information**: I understand that certain information collected by Haberle Steel, Inc., including some collected using this form, must be sent to the carriers of the plans in which I have enrolled. Haberle Steel, Inc. and the insurance carriers will treat this information as confidential.

Employee Signature: **Date:**