



# Benefit Election Form

Plan Year 01/01/2026 to 12/31/2026  
Weekly Pre-Tax Deductions (52 weeks)

A. EMPLOYEE INFORMATION			
Employee Name:		SSN:	
Home Address: (if <b>new address</b> , please check this box <input type="checkbox"/> )		City:	State: Zip Code:
Date of Birth:	Date of Hire:	Phone #:	Gender (circle): MALE FEMALE
Email:			
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Reinstatement <input type="checkbox"/> Maintain Current Coverage & Enrollment <input type="checkbox"/> Other			
Spouse Name:		Date of Birth:	SSN:
Child Name:		Date of Birth:	SSN:
Child Name:		Date of Birth:	SSN:
Child Name:		Date of Birth:	SSN:
B. Benefit Election		In accordance with Health Care Reform requirements, premium rates will be based on the employee, spouse, and dependents age at the time of enrollment. 2026 BCN HSA Silver Option 3 (formerly named) Blue Care Network HMO HSA \$5,000-0% – Weekly Deduction	
<input type="checkbox"/> Employee		\$49.30	
If you are electing to add a spouse or dependent to your policy, please contact Human Resources for additional details on the additional Weekly Payroll Deduction.			
<input type="checkbox"/> Spouse	Name:	Date of Birth:	Gender:
<input type="checkbox"/> Dependent	Name:	Date of Birth:	Gender:
<input type="checkbox"/> Dependent	Name:	Date of Birth:	Gender:
<input type="checkbox"/> <b>I decline Medical coverage because I have qualified coverage elsewhere.</b> I understand that I cannot change my election until the next open enrollment unless I have an eligible change in status.			
C. Voluntary Dental		Beam Dental PPO Plan – Weekly Deduction	
<input type="checkbox"/> Employee		<input type="checkbox"/> \$9.51	
<input type="checkbox"/> Employee + Spouse		<input type="checkbox"/> \$19.02	
<input type="checkbox"/> Employee + Child(ren)		<input type="checkbox"/> \$22.77	
<input type="checkbox"/> Employee + Family		<input type="checkbox"/> \$35.27	
<input type="checkbox"/> Waive Coverage			
<input type="checkbox"/> <b>I decline Voluntary Dental coverage because I have qualified coverage elsewhere.</b> I understand that I cannot change my election until the next open enrollment unless I have an eligible change in status.			



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D. Voluntary Vision	Beam/VSP Vision Plan – Weekly Deduction
<input type="checkbox"/> Employee	<input type="checkbox"/> \$1.62
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> \$3.25
<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> \$3.48
<input type="checkbox"/> Family	<input type="checkbox"/> \$5.55
<input type="checkbox"/> Waive Coverage	
<input type="checkbox"/> <b>I decline Voluntary Vision coverage because I have qualified coverage elsewhere.</b> I understand that I cannot change my election until the next open enrollment unless I have an eligible change in status.	
<b>E. Authorization</b>	
<p>I understand that:</p> <p>My regular pay will be reduced by the amount of my required contribution for the benefit options I have elected above and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option selected is set forth in the Annual Enrollment materials that have been provided to me.</p> <p>I cannot change or revoke this benefit election or compensation reduction agreement to be effective as of any date prior to next January 1, unless that change, or revocation is on account of and consistent with an eligible change in status or other such events as the plan administrator determines will permit a change or revocation of an election.</p> <p>Prior to January 1 of each year, I will be offered the opportunity to change my benefit elections for the following plan year (January 1 – December 31). If I do not complete and return a new Comfort Keepers Benefit Election Form at that time, I will be treated as having <u>not</u> elected to continue for the new plan year those benefits which are available to me.</p> <p>My signature below, acknowledges all choices on this enrollment form.</p>	
Employee Signature:	Date:

All carrier forms (Enrollment or Waiver) and this Election Form need to be returned to Comfort Keepers. This includes those electing coverage or waiving coverage. Eligible **newly hired** employees who do not return the forms back will be considered as having waived coverage and will not have another opportunity to enroll until the next Open Enrollment period.

### Who Do You BENEFIT With?

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