Name:_____

City Construction
2026-2027 Benefit Election Form

Rates listed are the employee weekly rate. Employee premiums are taken on ***pre-tax*** *basis.*

Medical Coverage (form must be completed if not currently enrolled in medical coverage or adding a dependent)

_____ I elect Plan 1 – **Wellmark CompleteBlue Primary 6250 PPO**

Type of Coverage:
_____Single
_____EE + Spouse
_____EE + Children
_____Family

_____I elect Plan 2 – Wellmark Enhanced Blue 1500 HMO

Type of Coverage:
_____Single
_____EE + Spouse
_____EE + Children
_____Family

Dental Coverage

_____ I elect Dental coverage (form must be completed if not currently enrolled in dental coverage)

Type of Coverage:_____ Single - $8.82
_____EE + Spouse - $17.64
_____EE + Children - $8.82 – Plus $6.67 Per Child (3+)
_____Family - $17.64 – Plus $6.67 Per Child (3+)

Name:_____

Vision Coverage

_____ I elect Vision coverage (form must be completed if not currently enrolled in Vision coverage)

Type of Coverage:_____ Single: $1.69
_____EE + Spouse: $3.20
_____EE + Children: $3.62
_____Family: $4.79

Short Term Disability Coverage

_____I elect Short Term Disability coverage(form must be completed)

Waiver of Coverage

_____I waive coverage for the medical plan

_____I waive coverage for the dental plan

_____I waive coverage for the vision plan

_____I waive coverage for the Short-Term Disability plan

I understand this pre-tax premium election will remain the same for the policy time period of October 1, 2026 – September 30, 2027 unless a qualified life event occurs as outlined in the IRS guidelines. I authorize City Construction to automatically deduct from my paycheck the necessary deductions to cover my insurance costs.

_____

Signature Date

_____

Print Name