Employee Election Form I 2026 Plan Year

ALL **BENEFIT-ELIGIBLE EMPLOYEES ARE REQUIRED** TO **COMPLETE THIS FORM!**

Employee Name (printed) Date of Birth Social Security Number

You must also complete and return the applicable application/enrollment form(s) specific to your elections. Please note that all required forms must be completed in their entirety and returned to Carissa Fields no later than **December 15th, 2025.**

Medical Plan Election	Gravie Copay $3,000/$8,150	Gravie ComfortFit $5,000
Employee only	$197.50 ☐	$256.74 ☐
Employee + Spouse	$416.82 ☐	$557.32 ☐
Employee + Children	$385.71 ☐	$515.73 ☐
Employee + Family	$592.52 ☐	$770.10 ☐
Waive Medical Benefits ☐		

Dental Plan Election	Delta Dental
Employee only	$37.04 ☐
Employee + Spouse	$79.38 ☐
Employee + Children	$70.48 ☐
Employee + Family	$113.48 ☐
Waive Dental Benefits ☐	

Vision Plan Election	Delta Dental
Employee only	$8.14 ☐
Employee + Spouse	$15.48 ☐
Employee + Children	$17.56 ☐
Employee + Family	$23.22 ☐
Waive Vision Benefits ☐	

Voluntary Life

For more details refer to the enrollment guide

Coverage Amount		Increment		Rate		Monthly Cost
$	÷	$1,000	x	$_____	=	$

Waive Voluntary Life ☐

I understand that my elections are selected through the end of plan year specified and may not be changed unless I experience a Qualifying life Event. I agree to abide by the regulation and terms of the plans I have enrolled in according ta the Summary Plan Descriptions for each plan(when applicable). I authorize my employer to deduct from my paycheck all appropriate premiums based on my elections. I understand that I have the right ta ask far mare detailed information about each plan that I have enrolled in by contacting the Plan Administrator.

SIGN HERE _____ DATE _____