Print Name:_____

J E Adams
2026-2027 Benefit Election Form

Rates listed are the employee weekly rates.
*Employee premiums are taken on **pre-tax** basis for medical and on **post-tax** basis for all other coverages.*

In Network BENEFITS	Traditional Plan	HDHP Plan
Deductible	$2,500 Single $5,000 Family	$3,500 Single $7,000 Family
Coinsurance	30%	0%
Out of Pocket Maximum	$5,000 Single $10,000 Family	$3,500 Single $7,000 Family
Office Visit Copay	$25 Primary Care $80 Specialist $40 Urgent Care	0% after deductible
Preventive Office Copay	Covered at 100%	Covered at 100%
Emergency Room Copay	$250 copay	0% after deductible
Prescription Drug	$30/$65/$100/$240/$275/$325	0% after deductible

_____**Keep my medical, dental & vision elections the same**

If you want to make a change please mark the below options and complete enrollment forms (if required)
_____**I elect Traditional Medical Plan** _____**I elect High Deductible (HSA) Medical Plan**

_____Single - $23.35
_____EE + Spouse -$58.59
_____EE + Children - $52.55
_____Family - $75.88

You will also be enrolled in dental and vision coverage at no cost to you.

____ I am requesting a change to my dependent information, including adding, removing, or updating dependents. Please fill out the dependent information section below.

Waiver of Coverage

_____**I waive coverage for the medical/dental/vision plans**

.

Print Name:_____

HSA Bank Account If you would like to open a HSA account to go with your enrollment into the High Deductible (HSA) Medical plan please complete this section and Collins Community Bank will contact you about opening an account.

Name:_____
Address:_____
City, ST Zip:_____
Phone and email:_____
Driver License #, Issuing ST & Expiration Date:_____
(provide copy of license)

Flexible Spending Accounts If you would like to participate in the Flexible Spending Account options available. Please make you elections below.

Health Care FSA - Able to use for eligible medical, dental & vision expenses. Can elect up to $3,300 for the year (Jul 25-Jun 26)
Limited FSA - Able to use for eligible dental & vision expenses. Can elect up to $3,300 for the year (Jul 25-Jun 26)
Dependent Care FSA - Able to use for eligible daycare expense. Can elect up to $5,000 for the year (Jul 25-Jun 26)

	Per Pay Period	**# Pay Periods**	**Annual Election**
Health Care FSA	**$**_____	**x 52**	**$**_____
Limited FSA	**$**_____	**x 52**	**$**_____
Dependent Care FSA	**$**_____	**x 52**	**$**_____

Voluntary Life and Disability Insurance

Your life and disability elections will automatically rollover.

_____**Keep my Voluntary Life, STD and/or LTD elections the same**

If you want to make a change please mark the below options and complete enrollment form (if required)

_____**I elect to add or increase Vol Life insurance**
_____**I elect to add Vol STD insurance**
_____**I elect to add Vol LTD insurance**

_____**I elect to drop or decrease Vol Life insurance**
_____**I elect to drop Vol STD insurance**
_____**I elect to drop Vol LTD insurance**

Print Name:_____

Requested Dependent Change(s)

☐ Add Dependent ☐ Remove Dependent ☐ Update Dependent Information

Dependent Information

Dependent #1
Name: _____
Relationship: _____
Date of Birth: ____ / ____ / _____
Social Security Number: _____
☐ Add ☐ Remove ☐ Update

Dependent #2
Name: _____
Relationship: _____
Date of Birth: ____ / ____ / _____
Social Security Number: _____
☐ Add ☐ Remove ☐ Update

Dependent #3
Name: _____
Relationship: _____
Date of Birth: ____ / ____ / _____
Social Security Number: _____
☐ Add ☐ Remove ☐ Update

Benefit Coverage Impact

☐ Medical ☐ Dental ☐ Vision ☐ Health Care FSA ☐ Dependent Care FSA ☐ None (information update only)

Employee Certification

I certify that the information provided on this form is accurate and complete. I authorize my employer to make corresponding benefit and payroll deduction changes. I understand this pre-tax premium election will remain the same for the policy time period of July 1, 2026 – June 30, 2027, unless a qualified life event occurs as outlined in the IRS guidelines. I authorize J E Adams to automatically deduct from my paycheck the necessary deductions to cover my insurance costs.

_____

Signature Print Name Date