HI-SPEED INDUSTRIAL SERVICE

KEEPING YOUR FACILITY UP TO SPEED
EVERY DAY SINCE 1946

2022-2023 Benefits Enrollment Application

If you do not want to participate in any plan, mark the circle beside "WAIVE", sign and date.

Status Change Elections

	Coverage Additions	Coverage Termination Due to
◯ New Hire ◯ Open Enrollment ◯ Name Change ◯ Address Change ◯ Beneficiary Change	Date of Change _____ Department_____ ◯ Birth ◯ Adoption ◯ Marriage ◯ Spouse Employment Change	Date of Change _____ ◯ Spouse Employment Change ◯ Retirement ◯ Employment Status (PT to FT) ◯ Divorce ◯ Death (Spouse / Dependent) ◯ Loss of Eligibility

Employee Information

Employee Last Name, First Name, MI		Employee Social Security #	Employee Birthdate
Address	Apt. #	◯ Male ◯ Female	Date of Hire / Phone #
City	State / Zip	◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Legally Separated	
Annual Income	Occupation	Email Address	

Medical Insurance* – *Health Plans Inc. (HPI)/Cigna Network* (Employee Cost per Paycheck)

◯ **Employee Only** $ 107.26 ◯ **Employee + Spouse** $ 235.97 ◯ **Employee + Child(ren)** $ 203.81 ◯ **Family** $ 321.77

◯ **WAIVE** Medical Coverage

* If your spouse has Medical Insurance coverage available through his or her employer, you will not be allowed to cover them on the HI-Speed Medical plan. In those cases, coverage options would be limited to Employee Only or Employee + Child(ren) coverage.

Dental Insurance – *Sun Life* (Employee Cost per Paycheck)

◯ **Employee Only** $ 6.16 ◯ **Employee + 1 Dependent** $ 18.43 ◯ **Family** $ 40.59

◯ **WAIVE** Dental Coverage

Vision Insurance – *Sun Life* (Employee Cost per Paycheck)

◯ **Employee Only** $1.48 ◯ **Employee + Spouse** $2.80 ◯ **Employee + Child(ren)** $3.29 ◯ **Family** $4.61

◯ **WAIVE** Vision Coverage

Family Information – *List only the dependents you want covered on the coverages listed and indicate which plan(s).*

Full Name of Dependent	Social Security #	Relationship	Gender	Birthdate	Benefit Election
01		◯ Spouse ◯ Child	◯ Male ◯ Female		◯ Medical ◯ Dental ◯ Vision ◯ Cancer ◯ Accident ◯ Critical Illness
02		◯ Spouse ◯ Child	◯ Male ◯ Female		◯ Medical ◯ Dental ◯ Vision ◯ Cancer ◯ Accident ◯ Critical Illness
03		◯ Spouse ◯ Child	◯ Male ◯ Female		◯ Medical ◯ Dental ◯ Vision ◯ Cancer ◯ Accident ◯ Critical Illness

* If you have more than 3 dependents, please provide their information on the next page.

- Over -

Basic Life and AD&D Insurance + Long-Term Disability Insurance – *Sun Life*

✓ Hi-Speed Industrial Service provides full-time Employees with 100% paid $25,000 of Basic Life and AD&D, plus Long-Term Disability.

Supplemental Life and AD&D Insurance – *Sun Life*

Employee and Dependent Coverage	Age	Monthly Premium*	Benefit Amount
Employee *Maximum of $500,000 or 5x annual earnings* *Guaranteed Issue is $100,000* *In amounts in excess of $100,000, an Evidence of Insurability Form will be required.*	Under age 35 35 – 39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 85+	$0.175 $0.20 $0.27 $0.37 $0.55 $0.84 $1.25 $2.02 $4.06 $7.27 $14.39 $26.47	◯ $10,000 ◯ $20,000 ◯ $30,000 ◯ $40,000 ◯ $50,000 ◯ $60,000 ◯ $70,000 ◯ $80,000 ◯ $90,000 ◯ $100,000 ◯ Amount in excess of $100k $_____ *(Increments of $10,000)* ◯ **WAIVE** Coverage
Spouse (Employee must elect coverage to elect Spouse coverage.) *Maximum of $250,000* *Guaranteed Issue is $25,000* *In amounts in excess of $25,000, an Evidence of Insurability Form will be required.*	Under age 35 35 – 39 40-44 45-49 50-54 55-59 60-64 65-69	$0.175 $0.20 $0.27 $0.37 $0.55 $0.84 $1.25 $2.02	◯ $5,000 ◯ $10,000 ◯ $15,000 ◯ $20,000 ◯ $25,000 ◯ Amount in excess of $25k $_____ *(Increments of $5,000)* ◯ **WAIVE** Coverage
Child(ren) (Employee must elect coverage to elect Child coverage.)	To age 19 (or 26 if FT student) $2.80 (Monthly Total for All Children)		◯ $10,000 (per child) ◯ **WAIVE** Coverage

***The Monthly Premium is for each $1,000 of Life Insurance coverage**

Supplemental Coverages – *Sun Life*

◯ **Short-Term Disability**

◯ **Cancer**
☐ Level 1 (low) ☐ Level 2 (high)
◯ Employee Only
◯ Employee + Spouse
◯ Employee + Child(ren)
◯ Family
Used tobacco in any form in the past 12 months? ☐ Yes ☐ No

◯ **Accident**
◯ Employee Only
◯ Employee + Spouse
◯ Employee + Child(ren)
◯ Family

◯ **Critical Illness**
Employee Amount $_____
Used tobacco in any form in the past 12 months? ☐ Yes ☐ No
Spouse Amount $_____
Used tobacco in any form in the past 12 months? ☐ Yes ☐ No
Child(ren) Amount $_____

WAIVE
◯ Short-Term Disability
◯ Accident
◯ Cancer
◯ Critical Illness

- Next Page -

HI-SPEED INDUSTRIAL SERVICE

KEEPING YOUR FACILITY UP TO SPEED
EVERY DAY SINCE 1946

2022-2023 Benefits Enrollment Application

(Continued)

Beneficiary Information

Primary Beneficiary Designation

Full Name of Beneficiary	Social Security #	Date of Birth	Address	Relationship	Percentage
01					
02					

Contingent Beneficiary Designation

01					
02					

I certify the facts contained in this summary are true and complete to the best of my knowledge.

I understand that being offered this coverage, I am no longer eligible for a subsidy through the exchange and as an elgible employee,

I acknowledge that I understand the benefits, rights, and obligations available to me under the plan including:
HI-Speed Industrial Service has a positive enrollment process for benefits for all eligible employees.
I am not required to participate in a medical plan and that I can decline coverage during this enrollment period of /1/22-02/28/22.
I understand that my pay will be reduced by the amount of any required contributions noted for the coverage(s) elected where the contributions are pre-tax, that I have the option of having required contributions taken from my pay on a post-tax basis and that I should notify my HR department in that event.

I understand that my coverage elections on this form cannot be REVOKED or MODIFIED during the year unless I have a QUALIFYING EVENT change in status as defined by the IRS and I may change my coverage elections during the next open enrollment period."

Signature: _____ Date: _____

Additional Family Information – *List only the dependents you want covered on the coverages listed and indicate which plan(s).*

Full Name of Dependent	Social Security #	Relation	Gender	Birthdate	Benefit Election
04		◯ Spouse ◯ Child	◯ Male ◯ Female		◯ Medical ◯ Dental ◯ Vision ◯ Cancer ◯ Accident ◯ Critical Illness
05		◯ Spouse ◯ Child	◯ Male ◯ Female		◯ Medical ◯ Dental ◯ Vision ◯ Cancer ◯ Accident ◯ Critical Illness
06		◯ Spouse ◯ Child	◯ Male ◯ Female		◯ Medical ◯ Dental ◯ Vision ◯ Cancer ◯ Accident ◯ Critical Illness