NEOS CONSULTING GROUP

2014 Benefits Election Form

Please make your benefit selections below, and sign and return this form to Human Resources. **You must complete this form even if you are waiving all coverage.** Refer to the second page for plan prices.

Employee First Name	Middle Initial	Last Name

Employee Social Security Number (last 4 digits only)

xxx-xx-

Health Insurance – Humana

I choose the following health insurance coverage:

- ☐ Option 1: $1,000-80%- PPO OPT 9
- ☐ Option 2: $2,000-80%- PPO OPT 11
- ☐ **Waive**: I choose not to participate in the medical plan. (Indicate reason below)
  - ☐ Covered under parent/spouse's plan
  - ☐ Covered under an Affordable Care Act Exchange plan
  - ☐ Can't afford coverage
  - ☐ Other reason:_____

Please choose one of the following coverage categories if you wish to enroll:

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

AGE-BAND MEDICAL RATES:

The Affordable Care Act requires new rating structures for small group health plans. In Texas, a small group is one that has fewer than 50 employees. As of January 1, 2015, all fully insured small group health plans are required to comply with the new "community rating" underwriting standards and age-banded rates. Since the rates are age-banded please provide the gender and dates of birth for all individuals that you wish to cover under this group plan.

	Gender	Date of Birth
Employee		
Spouse		
Child-1		
Child-2		
Child-3		
Child-4		

Dental Insurance – Dental Select

I choose the following dental insurance coverage:

- ☐ Option 1: Indemnity Dental Plan
- ☐ **Waive**: I choose not to participate in the dental plan.

Please choose one of the following coverage categories if you wish to enroll:

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

****CONTINUED ON SECOND PAGE****

Vision Insurance – Dental Select

I choose the following vision insurance coverage:

☐ Option 1: Voluntary Vision Plan

☐ **Waive**: I choose not to participate in the vision plan.

Please choose one of the following coverage categories if you wish to enroll:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Basic Life/AD&D Insurance – Lincoln Financial Group

☒ Mandatory enrollment (Employer paid line of coverage)

Special Enrollment Notice and Certification – Please review and sign at the bottom.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. If I am declining enrollment as indicated above, I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Election Irrevocable Unless Exception Applies

I understand that I cannot change or revoke this agreement as of any date prior to the next Plan Year, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage), and the election change is on account of and consistent with the Change in Election Event, as described in the Plan.

Election of Pre-tax Benefits — by signing below, I elect to receive benefit coverage under the Neos Consulting Group group plans. I understand that an amount equal to the annual contributions for the coverage I elect, divided by the number of pay periods in the Plan Year, will be deducted on a pre-tax basis from each of my paychecks to pay for my elected coverage.

Additional Terms

I agree that my compensation will be reduced by the amount of my required contribution for the benefits that I have elected under the Plan and that such salary reductions will continue for each pay period until this agreement is amended or terminated.

I have read and agree to the terms of participation and to any applicable certifications set forth in this agreement. Any previous election and agreement under the Plan relating to the same benefits, including any prior Cafeteria Plan Pre-tax Salary Reduction Acknowledgement Agreement, is hereby revoked.

Signature	Date

Per Pay Period Deductions: 24 Pay Periods

Health Insurance	Option 1	Option 2
Employee Only	$85.02	$0.00
Employee + Spouse	Age-Rated; See Admin	Age-Rated; See Admin
Employee + Children	Age-Rated; See Admin	Age-Rated; See Admin
Employee + Family	Age-Rated; See Admin	Age-Rated; See Admin

Dental Insurance	Option 1	Vision Insurance	Option 1
Employee Only	$0.00	Employee Only	$0.00
Employee + Spouse	$30.43	Employee + Spouse	$3.29
Employee + Children	$22.30	Employee + Children	$3.66
Employee + Family	$53.64	Employee + Family	$7.32

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