Evergreen
Possibilities await.

Benefit Election & Waiver Form

Please complete the following election form for your 2024 benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Evergreen Retirement Community, Inc. and are therefore waiving all coverage, please check the box for waiving all coverage. If waiving all coverage, complete only the top section of the form and sign/date at the bottom of the back page. You must provide a reason for waiving the coverage.

_____ New Hire _____ Change of Status* _____ Open Enrollment _____ Waiving All Coverage**

*List Qualifying Event _____

**List Reason for Waiving _____

*Change of Status is only applicable if you have experienced a qualifying event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. See HR with questions.
**Please note that all benefit eligible employees will be enrolled in employer sponsored Basic Life and AD&D.

Employee Information

Employee Name: _____ Date of Hire: _____/_____/_____

Address: _____ City, State, ZIP: _____

DOB: _____/_____/_____ Phone Number: _____ Marital Status: _____

Email: _____

Medical Coverage Election

Centivo High Performance Plan (WI-3 Network)
____ Employee Only - $65.00 biweekly
____ Employee + Spouse - $145.00 biweekly
____ Employee + Child(ren) - $135.00 biweekly
____ Family - $195.00 biweekly

____ Waive Medical Coverage, List reason: _____

Dental Coverage Election

Humana PPO/Traditional Preferred Plan
____ Employee Only - $5.00 biweekly
____ Family - $14.00 biweekly

_____ Waive Dental Coverage

Vision Coverage Election

Humana Insight Network
____ Employee Only - $7.69 monthly
____ Employee + Spouse - $15.38 monthly
____ Employee + Child(ren) - $14.61 monthly
____ Family - $20.28 monthly

_____ Waive Vision Coverage

Dependent Information

Please complete all information for dependents and check which coverage(s) you are enrolling them in.

First Name, MI, Last Name	SSN	DOB	Gender	Relationship	Medical	Dental	Vision

Will you be covered by any other medical, dental or vision plans in addition to Evergreen's? _____ No _____ Yes

If Yes, please list other coverage here _____
_____

Will any dependents that you are enrolling in Evergreen's medical, dental or vision plans be covered by any other medical, dental or vision plan(s) in addition to Evergreen's? _____ No _____ Yes

If Yes, please list other coverage here _____
_____

Voluntary Long Term Disability Coverage

Email Erin Sanders at esanders@evergreenoshkosh.com or call 920-237-2132 to request the Long Term Disability informational packet and enrollment form.

_____ Enroll in Long Term Disability Coverage _____ Waive Long Term Disability Coverage

Authorization and Signature

Every benefit eligible employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes will be during the 2025 open enrollment period for a 1/1/2025 effective date, unless you experience a qualifying life event. If you experience a qualifying life event, you must contact Human Resources within 30 days of the event.

If you are enrolling as a new hire, you must return your form to Human Resources within 30 days of your date of hire to be enrolled.

My signature below authorizes Evergreen Retirement Community, Inc. to deduct insurance premiums on a pre-tax basis.

Signature: _____ Date: _____/_____/_____