JOHN RICHMOND LANDSCAPING, INC.

Annual Election and Salary Reduction Agreement

Employee Election for Plan Year Beginning: 2020-21

EMPLOYEE INFORMATION

Name:	Work Phone#:
Occupation / Job Title	Location:
Home Address:	Home/Cell Phone#:
City, State, & Zip:	S.S.#:
Email:	Birth Date:

☐ No Change from Last Year ☐ This is a Change from Last Year

ELECTION OF PARTICIPATION

I want to participate in this Plan. I hereby make the following election regarding the benefits available to me under the Cafeteria Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular paycheck during the current Plan Year.

I understand that I can not change this election during the plan year unless a change of status occurs such as a marriage, divorce, birth or termination.

*** **Signature:** **Date:**

GROUP INSURANCE PLANS

Election #1: Group Medical Insurance

Check Plan	Group Insurance Plan Description		Monthly Cost	Participant AGE	Number of Deductions	Cost Per Pay
	Anthem Healthkeepers					
	Option #1 Bronze					
	Employee Coverage				52	
	Spouse Coverage				52	
	Child Coverage				52	
	Option #2 Silver					
	Employee Coverage				52	
	Spouse Coverage				52	
	Child Coverage				52	
	Option #3 Gold					
	Employee Coverage				52	
	Spouse Coverage				52	
	Child Coverage				52	

☐ No Change from Last Year ☐ This is a Change from Last Year

OPTION #2 GROUP DENTAL INSURANCE PLANS

Check Plan	Group Insurance Plan Description	Type of Coverage	Election Amount		
			$/Pay	# Pay periods	Monthly Cost
	Dominion Dental Insurance - HMO	**EE Only**	**$5.44**	**52**	**$23.58**
	Dominion Dental Insurance - HMO	**EE+1 Dep**	**$9.87**	**52**	**$42.76**
	Dominion Dental Insurance - HMO	**EE+2 or more**	**$14.72**	**52**	**$63.80**
	Dominion Dental Insurance - PPO	**EE Only**	**$7.21**	**52**	**$31.24**
	Dominion Dental Insurance - PPO	**EE+1 Dep**	**$13.28**	**52**	**$57.54**
	Dominion Dental Insurance - PPO	**EE+2 or more**	**$20.60**	**52**	**$89.28**

OPTION #3 GROUP SUPPLEMENTAL INSURANCE PLANS

Check Plan	Group Insurance Plan Description	Type of Coverage	Election Amount		
			$/Pay	# Pay periods	Monthly Cost
	Allstate - Accident Insurance	**EE Only**	**$4.25**	**52**	**$18.40**
	Allstate - Accident Insurance	**EE+Family**	**$7.11**	**52**	**$30.80**
	Allstate - Disability Insurance	**EE Only**	**$8.04**	**52**	**$34.84**
	Allstate - Disability Insurance	**EE +Family**	**$10.90**	**52**	**$47.24**
	Allstate - Term Life Insurance	**EE Only**		**52**	
	Allstate - Term Life Insurance	**EE Spouse**		**52**	
	Allstate - Term Life Insurance	**EE+ Children**		**52**	
	Allstate - Cancer Insurance	**EE Only**	**$4.61**	**52**	**$19.96**
	Allstate - Cancer Insurance	**EE+Family**	**$7.76**	**52**	**$33.62**

DEPENDENT INFORMATION

First Name	Last Name	SSN#	D.O.B.	Relationship

ELECTION OF PARTICIPATION

I want to participate in this Plan. I hereby make the following election regarding the benefits available to me under the Cafeteria Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular paycheck during the current Plan Year.

I understand that I can not change this election during the plan year unless a change of status occurs such as a marriage, divorce, birth or termination.

*** **Signature:** **Date:**