RICHMOND Waterproofing PRIMOID, INC. Concrete Structural Restoration

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

GROUP INSURANCE PLANS

Election #1: Group Medical Insurance

Check Plan	Group Insurance Plan Description	Monthly Cost	Number of Deductions	Cost Per Pay
	Anthem Healthkeepers			
	Option #1 Healthkeepers 30/5000/30			
	Employee Only	**$432.09**	**52**	**$53.56**
	Employee + Child	**$590.23**	**52**	**$90.05**
	Employee + Children	**$878.43**	**52**	**$156.56**
	Employee + Spouse	**$967.87**	**52**	**$177.20**
	Employee + Family	**$1,332.98**	**52**	**$261.46**
	Option #2 Healthkeepers 30/2000/30 Value Advantage			
	Employee Only	**$482.54**	**52**	**$65.20**
	Employee + Child	**$659.15**	**52**	**$105.96**
	Employee + Children	**$981.01**	**52**	**$180.23**
	Employee + Spouse	**$1,080.89**	**52**	**$203.28**
	Employee + Family	**$1,488.65**	**52**	**$297.38**
	Option #3 Healthkeepers 25/30 Point of Service			
	Employee Only	**$596.08**	**52**	**$91.40**
	Employee + Child	**$814.24**	**52**	**$141.75**
	Employee + Children	**$1,211.82**	**52**	**$233.50**
	Employee + Spouse	**$1,335.20**	**52**	**$261.97**
	Employee + Family	**$1,838.88**	**52**	**$378.20**

DEPENDENT INFORMATION

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

❑ NO CHANGE FROM LAST YEAR ❑ THIS IS A CHANGE FROM LAST YEAR

OPTION #2 GROUP DENTAL & VISION

Check Plan	Group Insurance Plan Description	Type of Coverage	Election Amount		
			Monthly Cost	# Pay periods	$/Pay
	Dominion Dental Insurance - HMO	**EE Only**	**$23.58**	**52**	**$5.44**
	Dominion Dental Insurance - HMO	**EE+1 Dep**	**$42.76**	**52**	**$9.87**
	Dominion Dental Insurance - HMO	**EE+2 or more**	**$63.30**	**52**	**$14.61**
	Dominion Dental Insurance - PPO	**EE Only**	**$33.66**	**52**	**$7.77**
	Dominion Dental Insurance - PPO	**EE+1 Dep**	**$62.02**	**52**	**$14.31**
	Dominion Dental Insurance - PPO	**EE+2 or more**	**$96.30**	**52**	**$22.22**
	Dominion Vision Insurance	**EE Only**	**$11.28**	**52**	**$2.60**
	Dominion Vision Insurance	**EE+1 Dep**	**$18.82**	**52**	**$4.34**
	Dominion Vision Insurance	**EE+2 or more**	**$26.78**	**52**	**$6.18**

❑ NO CHANGE FROM LAST YEAR ❑ THIS IS A CHANGE FROM LAST YEAR

OPTION #3 GROUP SUPPLEMENTAL INSURANCE PLANS

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

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. I understand that the cost includes all ACA, administrative and billing fees.

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

DECLINE PARTICIPATION

I do not want to participate in this Plan. I decline the following elections regarding the benefits available to me under the Cafeteria Plan. I understand that I may change elections at next open enrollment.

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