BENEFITS ENROLLMENT FORM

1. EMPLOYEE INFORMATION

Name (please print):		Social Security #:
Address:	Date of Birth (MM/DD/YYYY):	Date of Hire:
City:	State:	ZIP:
Phone Number:	Email Address:	

2. MEDICAL PLAN SELECTION (PER-MONTH)

Please check (✓) one box
Medical Coverage includes Prescription Drug Coverage

	Anthem Blue Cross PPO Plan	Kaiser HMO $15 Plan	Kaiser HMO $1,000 DHMO	Kaiser HSA $2,000 Plan
Employee Only	☐ $191.35	☐ $188.08	☐ $87.26	☐ $74.67
Employee + Spouse/Domestic Partner	☐ $867.11	☐ $870.64	☐ $459.95	☐ $393.50
Employee + Child(ren)	☐ $707.99	☐ $672.77	☐ $370.87	☐ $264.40
Family	☐ $1,178.30	☐ $1,163.50	☐ $721.56	☐ $594.44

☐ **Waive Medical Coverage**

3. HEALTH SAVINGS ACCOUNT (HSA)

Please check (✓) one box

If you elect to participate in the plan, you may contribute funds to an HSA on a pre-tax basis. The annual HSA contribution maximums are **$4,400 for Employee Only coverage** and **$8,750 for all other coverage levels** inclusive of company contributions as well. If you are age 55 or older, you may contribute an additional $1,000 (regardless of the coverage level you elected).

CGW will contribute **$600 for Employee Only coverage**, **$1,200 for Employee + Spouse coverage**, and **$1,200 for Family Coverage** toward the HSA.

If you are interested in participating in the HSA, please check the box below, and choose your HSA plan and list your annual and per-pay contribution amounts.

☐ **Yes,** I would like to participate in the HSA. **Annual Contribution:** $_____ **OR** **Per Pay Period Contribution:** $_____

☐ **No,** I do not wish to participate in the HSA.

4. SPENDING ACCOUNTS

Healthcare Flexible Spending Account (FSA)*
Maximum: $3,400

Annual Contribution: $_____

Dependent Care Flexible Spending Account (DCFSA)**
Maximum: $7,500 / $3,750 if married, filing separately

Annual Contribution: $_____

☐ **No,** I do not wish to participate in the Spending Accounts.

* *Choose the Healthcare FSA if enrolling in the PPO medical plan, or if you are not enrolling in a medical plan, but still wish to participate in an FSA.*

** *For 2026, any employee with a base salary of at least $160k will be considered a Highly-Compensated Employee and be limited to an annual DCFSA contribution of $4,000.*

5. DENTAL PLAN SELECTION (PER-MONTH)

Please check (✓) one box

	Delta Dental PPO
Employee Only	☐ $0.00
Employee + Spouse/Domestic Partner	☐ $48.79
Employee + Child(ren)	☐ $47.80
Family	☐ $68.28

☐ **Waive Dental Coverage**

6. VISION PLAN SELECTION (PER-MONTH)

Please check (✓) one box

	VSP Vision Plan
Employee Only	☐ $0.00
Employee + Spouse/Domestic Partner	☐ $6.62
Employee + Child(ren)	☐ $6.70
Family	☐ $14.70

☐ **Waive Vision Coverage**

7. DEPENDENT ENROLLMENT INFORMATION

Dependent First & Last Name	Gender (M/F)	Relationship (Spouse, DP, Child)	Date of Birth (MM/DD/YYYY)	Social Security # (required)	Select Plan(s) to Add/Cancel
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision

8. METLIFE LEGAL PLAN

Please check (✓) one box

☐ **Yes,** I wish to elect the MetLIfe Legal Plan
$16.50 Monthly via payroll deduction
Family coverage included at no additional cost including spouse and dependents.

☐ **No,** I do not wish to elect the MetLife Legal Plan.

9. NORTON LIFE LOCK

Please check (✓) one box

	Premier Plan	Premier Plan Plus
Employee Only	☐ $9.49	☐ $12.49
Employee + Family	☐ $17.98	☐ $21.48

☐ **No,** I do not wish to elect the Norton Life Lock Plan.

10. ALLSTATE LIFE/LONG-TERM CARE*

Please check (✓) one box

Employee Only	☐ **Yes,** I wish to elect Allstate Life/Long-Term Care coverage. **Requested Face Amount (up to $200,000):** $_____
	☐ **No,** I do not wish to elect Allstate Life/Long-Term Care coverage.
Spouse/Domestic Partner	☐ **Yes,** I wish to elect Allstate Life/Long-Term Care coverage. **Requested Face Amount (up to $200,000):** $_____
	☐ **No,** I do not wish to elect Allstate Life/Long-Term Care coverage.

**Please see Rates and premiums on separate rate sheet.*

11. TOBACCO USER

Please check (✓) one box

This question only applies to the following Voluntary Benefit: Voluntary Allstate Whole Life with Long-Term Care. This information is confidential and will not be shared or used in evaluating for any benefit plans and only used to determine your rates should you apply.

Have you used tobacco in the last 12 months?

☐ **Yes,** I have used to tobacco in the last 12 months

☐ **No,** I have not used tobacco in the last 12 months

12. INSURANCE COVERAGE - LIFE/AD&D, SHORT-TERM DISABILITY (STD), LONG-TERM DISABILITY (LTD)

CGW pays 100% of premiums for Life and Accidental Death and Dismemberment (AD&D) Insurance, Short-Term and Long-Term Disability Insurances.

- Crystal Geyser provides eligible employees with group life and AD&D insurance. The basic Term Life and Basic AD&D Benefit equals $50,000
- Short-Term Disability (STD) replaces 60% of weekly base salary (up to $3,000) to employees up to 26 weeks.
- Long-Term Disability (LTD) replaces 60% of monthly base salary (up to $10,000) to employees who are disabled beyond 180 days.

Please indicate your beneficiary designation for your Life Insurance benefits in the event of your death. You may indicate a Primary and Contingent Beneficiary. You may also name more than one Primary and/or Contingent Beneficiary. Unless designated otherwise, payment will be made in equal shares or all to the survivor. You have the right to change this beneficiary designation at any time. If you would like to designate different beneficiaries on each insurance plan, please notify Human Resources.

13. BENEFICIARY INFORMATION

Beneficiary Name (please print):		Beneficiary Type: ☐ Primary ☐ Contingent
Beneficiary Address:	Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):
Phone Number:	Email Address:	
Relationship:	% of Benefit:	

Beneficiary Name (please print):		Beneficiary Type: ☐ Primary ☐ Contingent
Beneficiary Address:	Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):
Phone Number:	Email Address:	
Relationship:	% of Benefit:	

Beneficiary Name (please print):		Beneficiary Type: ☐ Primary ☐ Contingent
Beneficiary Address:	Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):
Phone Number:	Email Address:	
Relationship:	% of Benefit:	

14. VOLUNTARY LIFE/AD&D INSURANCE – EMPLOYEE

Please check (✓) one box

Employees have the option of purchasing additional Life and AD&D coverage through Lincoln Financial Group. You may purchase coverage in increments of $10,000 up to a maximum of 6x Annual Earnings or $750,000.

The Guarantee Issue amount is $250,000.

☐ **Yes,** I wish to elect Employee Voluntary Life and AD&D Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Employee Voluntary Life and AD&D

NOTE: You **must** elect Voluntary Employee Life and AD&D to participate in the following Voluntary Spouse and Child(ren) Life and AD&D Plans. Employee is responsible for 100% of the premium.

** An Evidence of Insurability (EOI) is needed after Guaranteed Issue is listed.*

**Please see Rates and premiums on separate rate sheet.*

15. VOLUNTARY LIFE/AD&D INSURANCE – SPOUSE

Please check (✓) one box

You may purchase Spousal coverage in increments of $5,000 up to a maximum of $250,000.

The Guarantee Issue amount is $50,000.

☐ **Yes,** I wish to elect Spousal Voluntary Life and AD&D Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Spousal Voluntary Life and AD&D

** An Evidence of Insurability (EOI) is needed after Guaranteed Issue is listed.*

**Please see Rates and premiums on separate rate sheet.*

16. VOLUNTARY LIFE/AD&D INSURANCE – CHILD(REN)

Please check (✓) one box

You may purchase Child coverage in increments of $2,000 up to a maximum of $20,000.

☐ **Yes,** I wish to elect Child(ren) Voluntary Life Coverage. **Election Amount:** _____

☐ **No,** I do not wish to elect Child(ren) Voluntary Life

**Please see Rates and premiums on separate rate sheet.*

17. VOLUNTARY CRITICAL ILLNESS

Please check (✓) one box

Employees have the option of purchasing Critical Illness coverage through Lincoln Financial. Coverage is available in the following tiers: $10,000, $20,000, $30,000, and $40,000.

☐ **Yes,** I wish to elect Employee Critical Illness Coverage.
Election Amount: _____

☐ **No,** I do not wish to elect Employee Critical Illness Coverage.

Please Note: Employee's children are covered automatically at 50% of the employee's coverage at no cost.

18. VOLUNTARY CRITICAL ILLNESS

Please check (✓) one box

Employees have the option of purchasing Critical Illness coverage through Lincoln Financial for their Spouse. Coverage is available in the following tiers: $10,000, $20,000, $30,000, and $40,000.

☐ **Yes,** I wish to elect Spousal Critical Illness Coverage.
Election Amount: _____

☐ **No,** I do not wish to elect Spousal Critical Illness Coverage.

CRITICAL ILLNESS RATES—MONTHLY RATES PER 10,000 OF EE COVERAGE

AGE	EMPLOYEE (OR EMPLOYEE CHILDREN)		SPOUSE (PER $5,000)		EMPLOYEE + SPOUSE (OR EMPLOYEE AND FAMILY)	
	NON-TOBACCO	TOBACCO	NON-TOBACCO	TOBACCO	NON-TOBACCO	TOBACCO
<25	$3.39	$3.71	$1.95	$2.15	$5.34	$5.86
25-29	$3.51	$4.04	$2.05	$2.34	$5.56	$6.38
30-34	$4.02	$4.93	$2.34	$2.87	$6.36	$7.80
35-39	$4.84	$6.71	$2.79	$3.88	$7.63	$10.59
40-44	$5.71	$8.52	$3.26	$4.82	$8.97	$13.34
45-49	$7.25	$11.90	$4.20	$6.87	$11.45	$18.77
50-54	$9.57	$16.11	$5.76	$9.54	$15.33	$25.65
55-59	$12.64	$21.49	$7.43	$12.44	$20.07	$33.93
60-64	$15.58	$25.99	$9.17	$15.10	$24.75	$41.09
65-69	$19.07	$30.28	$11.25	$17.77	$30.32	$48.05
70+	$26.23	$40.37	$15.70	$23.70	$41.93	$64.07

19. VOLUNTARY ACCIDENT INSURANCE (MONTHLY RATES)

Please check (✓) one box

	Lincoln Financial Voluntary Accident Plan Monthly Rates
Employee	☐ $7.05
Employee + Spouse/Domestic Partner	☐ $12.76
Employee + Child(ren)	☐ $16.85
Family	☐ $22.56

☐ **Waive Voluntary Accident Insurance**

20. VOLUNTARY HOSPITAL INDEMNITY (MONTHLY RATES)

Please check (✓) one box

	Lincoln Financial Voluntary Hospital Indemnity Monthly Rates
Employee	☐ $11.63
Employee + Spouse/Domestic Partner	☐ $26.92
Employee + Child(ren)	☐ $22.21
Family	☐ $36.95

☐ **Waive Voluntary Hospital Indemnity**

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the plan year, unless there is a qualified change in status under the terms of the plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through CGW during the open enrollment period each year and during the year within 30 days of a qualified change in status.

Additionally, due to the timing of enrollment, the bi-weekly premiums due for your benefit elections may not be reflected in your first paycheck. In this case, I acknowledge that the missed deductions will automatically be applied to my next paycheck.

Employee Signature: _____ **Date:** _____