FY 22/23 BENEFIT OPEN ENROLLMENT CHANGE FORM FOR VOLUNTARY BENEFITS WITH LINCOLN, TRANSAMERICA, ALLSTATE

Employee Name: **Employee #:** **Department:**

Complete this section for Disability Voluntary Benefit options ...

TYPE OF COVERAGE	ENROLLMENT SECTION	AMOUNT OF COVERAGE	BI-WEEKLY DEDUCTION (FOR 24 PAY PERIODS)
SHORT-TERM DISABILITY *EMPLOYEE ONLY COVERAGE* *Maximum of $500 per week, not to exceed 70% of salary and maximum duration of 13 weeks.*	☐ YES ☐ DECLINE	☐ $200 Weekly Amount ☐ $250 Weekly Amount ☐ $300 Weekly Amount ☐ $350 Weekly Amount ☐ Other Weekly Amount	☐ $8.63 ☐ $10.79 ☐ $12.95 ☐ $15.10 ☐ OTHER $ _____
LONG-TERM DISABILITY *EMPLOYEE ONLY COVERAGE* *Maximum of $2,000 per month, not to exceed 60% of monthly salary in $500 increments*	☐ YES ☐ DECLINE	☐ $500 Monthly Amount ☐ $1,000 Monthly Amount ☐ $1,500 Monthly Amount ☐ OTHER: $ _____	☐ $3.20 ☐ $6.40 ☐ $9.60 ☐ OTHER: $ _____

Complete this section for Employee, Spouse, and Dependent Life Insurance/AD&D Coverage ...

BASIC TERM LIFE/ AD&D *DEPENDENT COVERAGE ONLY*	☐ YES ☐ DECLINE	☐ SPOUSE ☐ CHILD(REN) # _____	**$0.89 Total Cost for All Who are Covered** $10,000 FOR SPOUSE & CHILD(REN) AGES 6 MONTHS TO 26 $1,000 FOR CHILD(REN) 14 DAYS TO 6 MONTHS
PART 1 OF 3: **VOLUNTARY LIFE** *EMPLOYEE ONLY* *Must purchase Life Insurance on Self if you want to purchase coverge on Spouse and/or Child(ren). Spouse coverage cannot exceed 100% of Employees coverge amount*	☐ YES ☐ DECLINE If electing coverage on Self, go to Part 2 of 3 below and elect coverage on Spouse, if desired		Cost is determined based on age and whether or not a tobacco user. If you elect this coverge, a Representative will reach out to you to further discuss. You MAY be required to provide a Statement Of Health, if so, HR will reach out to you. Spouse coverage cannot exceed 100% of Employees coverge amount.
PART 2 OF 3: **VOLUNTARY LIFE** *SPOUSE ONLY* *Must purchase Life Insurance on Self if you want to purchase coverge on Spouse. Spouse coverage cannot exceed 100% of your coverage*	☐ YES ☐ DECLINE If electing coverage on Self, go to Part 3 of 3 below and elect coverage on Child(ren), if desired		Cost is determined based on age and whether or not a tobacco user. If you elect this coverge, a Representative will reach out to you to further discuss. Spouse MAY be required to provide a Statement of Health, if so, HR will reach out to you.
PART 3 OF 3:	☐ YES ☐ DECLINE	☐ $5,000 # _____	☐ $0.60 Total cost for all Child(ren) covered

VOLUNTARY LIFE *CHILD(REN) ONLY* *You must purchase Life Insurance on Self if you want to purchase coverage on Child(ren)*		☐ $10,000 # _____	☐ $1.20 Total cost for all Child(ren) covered **Dependent MAY be required to provide a Statement of Health, if so, HR will reach out to you.**
VOLUNTARY AD&D EMPLOYEE, SPOUSE, AND/OR CHILD(REN) *Spouse maximum $250K NOT to exceed 50% of Employees Life Benefit amount*	☐ YES ☐ DECLINE	☐ **EMPLOYEE** ☐ $25,000 $0.29 ☐ $50,000 $0.58 ☐ $100,000 $1.15 ☐ $150,000 $1.73 ☐ OTHER: $ _____	☐ **SPOUSE** ☐ $12,500 $0.15 ☐ $25,000 $0.29 ☐ $50,000 $0.58 ☐ $75,000 $0.87 ☐ OTHER: $ _____ ☐ **CHILD(REN)** ☐ $5,000 $.09 ☐ $10,000 $0.18
TYPE OF COVERAGE	**ENROLLMENT SECTION**	**COVERAGE ELECTION**	**BI-WEEKLY DEDUCTION (FOR 24 PAY PERIODS)**
TRANSAMERICA CRITICAL ILLNESS *Maximum amount of coverage is $500K. You can purchase for Child(ren)*	☐ YES ☐ DECLINE If yes, please complete this section >>>>>>>>>>>>>>>	☐ EMPLOYEE ☐ SPOUSE ☐ CHILD(REN)	**Rates are dependent upon age and tobacco use. You will be contacted by a Representative regarding cost if you elect coverage**
TRANSAMERICA WHOLE LIFE *You may cover yourself, Spouse, Child(ren), and/or Grandchild(ren).*	☐ YES ☐ DECLINE If yes, please complete this section >>>>>>>>>>>>>>>	☐ EMPLOYEE ☐ SPOUSE ☐ CHILD(REN) ☐ GRANDCHILD(REN)	**Rates are dependent upon age and tobacco use. You will be contacted by a Representative regarding cost if you elect coverage**
TRANSAMERICA CANCER	☐ YES ☐ DECLINE If yes, please complete these sections >>>>>>>>>>>>>>>	☐ **PLAN 1:** *($3,000 INITIAL DIAGNOSIS)* ☐ **PLAN 2:** *($10,000 INITIAL DIAGNOSIS)*	☐ EMPLOYEE ONLY $10.31 ☐ EMPLOYEE + CHILD(REN) $11.86 ☐ EMPLOYEE + FAMILY $18.86 ☐ EMPLOYEE ONLY $19.61 ☐ EMPLOYEE + CHILD(REN) $22.09 ☐ EMPLOYEE + FAMILY $35.13
ALLSTATE ACCIDENT	☐ YES ☐ DECLINE	☐ EMPLOYEE ONLY ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + FAMILY	☐ EMPLOYEE ONLY $7.76 ☐ EMPLOYEE + SPOUSE $14.44 ☐ EMPLOYEE + CHILD(REN) $15.93 ☐ EMPLOYEE + FAMILY $19.64

I agree to the benefit changes as outlined in this Change Form for FY 22/23.

Employee Signature: **Date Signed:**