WELLINGTON BENEFITS
A MEMBER OF THE FIRST FINANCIAL GROUP
First in Service and Expertise

BENEFIT ELECTION/CHANGE FORM

☐ New Hire Enrollment ☐ Qualifying Event ☐ Termination ☐ Address Change

Termination Date _____ Date of first/last deduction _____

Section 1 - Life Event Change (Only complete if qualifying event)

You may make elections changes during the Section 125 Plan Year if you have a qualifying event and you notify the Benefits Department within 31 days of the event. Please complete all information.

Reason for request: ☐ Marriage / Divorce ☐ Death of a Spouse or Dependent ☐ Birth or Adoption of a Child

☐ Job Status Change for Employee or Spouse ☐ Termination/Commencement of Spouse's Employment

☐ Other (Please Explain):_____ **Effective Date of Change:**____/___/____

Section 2 – Employee Information (*Please Print*)

Employee Name:			Social Security Number	Date of Birth:
Gender:	Marital Status:	Phone Number:	Email address:	
Mailing Address:				
Physical Address *(required if mailing address is PO Box)*:				

For the Benefits Department use only:			
Annual Salary: $	Hire Date:	Occupation:	Location:
Hours worked:	Pay Frequency: ___10 ____12	Effective Date:	

Section 3 – Family Information (*Please Print)*

Dependent Name	SSN	DOB	M/F
Spouse			
Child			
Child			
Child			
Child			

Section 4 – Benefit Selection (*Please indicate election by using an "X"*)

Ameritas Dental ☐ Decline

☐ Employee Only
☐ Employee & Spouse
☐ Employee & Children
☐ Employee & Family

Ameritas Vision ☐ Decline

☐ Employee Only
☐ Employee & Family

Humana Short Term Disability ☐ Decline

Elimination Period:

☐ 0/7 ☐ 14/14 ☐ 30/30

Monthly Benefit Amount: $_____

Monthly Premium Amount: $_____

AFA Accident: ☐ Decline

☐ Basic ☐ Enhanced

☐ Employee Only
☐ Employee & Spouse
☐ Employee & Children
☐ Employee &Family

Premium: $_____

Humana Cancer ☐ Decline

☐ Employee Only
☐ Employee & Spouse
☐ Employee & Children
☐ Employee & Family

Benefit Amount: $_____

Premium Amount: $_____

Transamerica Critical Illness ☐ Decline

☐ Employee Only
☐ One Parent Family
☐ Two Parent Family

Benefit Amount: $_____

Premium Amount: $_____

Texas Life ☐ Decline

☐ Employee Coverage $_____
☐ Spouse Coverage $_____
☐ Child(ren) Coverage $_____

Reliance Standard Group Life ☐ Decline

☐ Employee Coverage $_____
☐ Spouse Coverage $_____
☐ Child(ren) $10,000

Combined Long Term Care ☐ Decline

☐ Check here, if interested in applying for coverage

Your agent, Harold Miller, will be in contact with you to complete your request for coverage. Please be sure you include a valid number above.

Flexible Spending Accounts ☐ Decline

☐ Medical Reimbursement
(*Maximum Annual Amount - $2,500)*
$_____ Annual Contribution

☐ Dependent Care Reimbursement
(*Maximum Annual Amount - $5,000)*
$_____ Annual Contribution

Section 5 – Beneficiary Designation (*Please Print)*

Primary Beneficiary:

Name_____

Date of Birth_____

Relationship_____

Percentage_____

Contingent Beneficiary:

Name_____

Date of Birth_____

Relationship_____

Percentage_____

Section 6 - Signatures

This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status. I understand that I have verified the benefits elected above and authorize any payroll deductions required for those elections. I understand any elections I have elected above are subject to the insurance company's underwriting guidelines and are not a guarantee the policy or policies will issue.

Employee Signature: x_____ Date: _____/_____/_____