CONTAINER PRODUCTS CORPORATION
2018 - 2019 BENEFITS - EMPLOYEE ENROLLMENT FORM

EE # _____ ☐ Hourly ☐ Salaried **Date of Hire** _____ **Eff. Date** _____

☐ NEW ENROLLMENT ☐ LOSS COVERAGE ☐ OPEN ENROLLMENT ☐ ADD DEPENDENT ☐ DROP DEPENDENT ☐ CANCEL COVERAGE

NAME _____ (Last, First MI)

HOME ADDRESS _____ (STREET)

_____ (CITY, STATE, ZIP)

_____ (EMAIL)

SS# _____ DOB _____

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed

HOME PHONE/CELL _____

Benefit Options (Weekly Deductions)

All benefit deductions are paid on a pre-tax basis.

MEDICAL OPTION

☐ Spouse Covered Under Another Plan ☐ Dependent(s) Covered Under Another Plan ☐ Not Participating

	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	EMPLOYEE/CHILD(REN)	EMPLOYEE/FAMILY
BCBS BASE	☐ $ 28.00	☐ $ 86.00	☐ $ 65.50	☐ $ 76.00	☐ $ 133.00
BCBS BUY-UP	☐ $ 36.00	☐ $ 102.00	☐ $ 79.50	☐ $ 90.00	☐ $ 157.00

WAIVE MEDICAL COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY DEPENDENT CHILD(REN)

I AM/DEPENDENTS COVERED BY: ☐ PREVIOUS EMPLOYER ☐ OUTSIDE INSURANCE PLAN ☐ UNDER SPOUSE/PARENT PLAN ☐ MEDICARE/MEDICAID

DENTAL OPTION

☐ NOT PARTICIPATING

	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	EMPLOYEE/CHILD(REN)	EMPLOYEE/FAMILY
GUARDIAN PPO	☐ $ 5.55	☐ $ 7.77	☐ $ 11.10	☐ $ 13.32	☐ $ 16.65

WAIVE MEDICAL COVERAGE FOR: ☐ MY SPOUSE ☐ MY DEPENDENT CHILD(REN)

I AM/DEPENDENTS COVERED BY: ☐ OUTSIDE INSURANCE PLAN ☐ UNDER SPOUSE/PARENT PLAN ☐ MEDICARE/MEDICAID

VISION OPTION

☐ NOT PARTICIPATING

EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD(REN)	EMPLOYEE/FAMILY
☐ $1.81	☐ $3.44	☐ $ 3.62	☐ $ 5.32

WAIVE MEDICAL COVERAGE FOR: ☐ MY SPOUSE ☐ MY DEPENDENT CHILD(REN)

I AM/DEPENDENTS COVERED BY: ☐ OUTSIDE INSURANCE PLAN ☐ UNDER SPOUSE/PARENT PLAN ☐ MEDICARE/MEDICAID

FLEXIBLE SPENDING ACCOUNTS (ENTER YOUR ANNUAL ELECTION)

☐ NOT PARTICIPATING

Health Care Account (Minimum $500.00 - Maximum $2,650.00 Annual)

Annual Election _____

Deduction per pay period _____

Dependent Coverage Information

You cannot enroll a dependent into a coverage that you are not enrolled in.

List all eligible dpendents.

RELATIONSHIP	FULL NAME	SSN*	BIRTH DATE	M/F	PLEASE INDICATE Y/N MEDICAL ♦	DENTAL ♦	VISION ♦
SELF							
SPOUSE					☐	☐	☐
DEPENDENT					☐	☐	☐
DEPENDENT					☐	☐	☐
DEPENDENT					☐	☐	☐
DEPENDENT					☐	☐	☐
DEPENDENT					☐	☐	☐
DEPENDENT					☐	☐	☐

♦ Unmarried dependent children to age 26, for whom the insured or the insured's spouse is legally responsible.

Life & Disability Insurance

LIFE INSURANCE (Group Coverage through Guardian) — CPC PAYS 100% OF THIS BENEFIT FOR EMPLOYEE, SPOUSE & DEPENDENTS UNDER AGE 21

Enter (Name, DOB, Gender) below to cover your spouse or other dependent(s) under Group Dependent Life

	Benefit Pays						Relationship
Employee	100% annual salary	Spouse's Name	DOB	Gender			
Spouse	$5,000	Dependent Name	DOB	Gender	☐ Son	☐ Daughter	
Dep/Child(ren)	$2,500	Dependent Name	DOB	Gender	☐ Son	☐ Daughter	
		Dependent Name	DOB	Gender	☐ Son	☐ Daughter	

LIFE INSURANCE BENEFICIARY DESIGNATION FOR BASE LIFE AND ACCIDENTAL & DISMEMBERMENT POLICIES

Container Products Corporation offers employer paid **Life/AD&D & Dependent Life** coverage through **Guardian.**

Please designate at least one Primary Beneficiary for your Life Insurance Policy (1 x annual salary). This beneficiary designation also serves as your beneficiary designation for AD&D & Disability Insurance as well.

PRIMARY BENEFICIARY _____ ADDRESS _____

RELATIONSHIP _____ _____

PERCENTAGE _____ _____

☐ SECONDARY BENEFICIARY or

☐ CONTINGENT BENEFICIARY _____ ADDRESS _____

RELATIONSHIP _____ _____

PERCENTAGE _____ _____

SHORT TERM DISABILITY INSURANCE — CPC PAYS 100% OF THIS BENEFIT FOR EMPLOYEE

Container Products Corporation offers employer paid **Short Term Disability** coverage through **Guardian.**

Voluntary LTD & Life Insurance

Voluntary Disability & Life benefit deductions are paid on a post-tax basis.

LONG TERM DISABILITY INSURANCE ☐ I ELECT LTD COVERAGE ☐ NOT PARTICIPATING*

Container Products Corporation also provides **Long Term Disability** coverage through **Guardian.** This plan is designed to provide a continuation of benefits to you in the event of a sickness or accident keeping you out of work for longer than 26 weeks. Your payroll deduction will be (.73 per $100 of your base salary).

Annual Salary _____

Payroll Deduction Amount (employer use only)

Weekly Rate **Bi-Weekly Rate**

IF YOU DECLINE AT INITIAL ELIGIBILITY, YOU BE REQUIRED TO PROVIDE MEDICAL DOCUMENTATION IN THE FUTURE

SUPPLEMENTAL LIFE INSURANCE BENEFICIARY DESIGNATION (CHOOSE OPTION FROM GUARDIAN BENEFIT BOOK) ☐ NOT PARTICIPATING

Please enter the policy amount(s) you chose from the Enrollment/Change Form..

Payroll Deduction Amount (employer use only)

Employee	$ _____	_____
Spouse	$ _____	_____
Dependent/Child(ren)	$ _____	_____

I have read the materials about my benefits, and I understand that by signing this form, I authorize the elections I made and any deductions from my pay. If I have not elected medical coverage, I certify I have coverage elsewhere. I understand my elections and supporting documentation (if applicable) must be submitted within 90 days of my hire date and that these elections will remain in effect until the next plan year. I understand that if I experience a qualifying life event that affects my beneftis, I am responsible for notifying the Office of Human Resources, and providing documentation, within 31 days of such event. I understand all benefits for myself and my eligible dependents will be provided in accordance with the Group Policy.

☐ Attached is a "Waiver Of Coverage" form that I have read, and understand I will only need to complete if I decide to decline **Medical Coverage Enrollment**.

_____ ⇦⇦ _____

Signature Date