

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 _____ HOME ADDRESS _____
Last, First MI STREET

SS# _____ DOB _____
CITY, STATE, ZIP EMAIL

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

	<u>EMPLOYEE ONLY</u>	<u>EMPLOYEE/SPOUSE</u>	<u>EMPLOYEE/CHILD</u>	<u>EMPLOYEE/CHILD(REN)</u>	<u>EMPLOYEE/FAMILY</u>
BCBS BASE	<input type="checkbox"/> \$ 28.00	<input type="checkbox"/> \$ 86.00	<input type="checkbox"/> \$ 65.50	<input type="checkbox"/> \$ 76.00	<input type="checkbox"/> \$ 133.00
BCBS BUY-UP	<input type="checkbox"/> \$ 36.00	<input type="checkbox"/> \$ 102.00	<input type="checkbox"/> \$ 79.50	<input type="checkbox"/> \$ 90.00	<input type="checkbox"/> \$ 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

	<u>EMPLOYEE ONLY</u>	<u>EMPLOYEE/SPOUSE</u>	<u>EMPLOYEE/CHILD</u>	<u>EMPLOYEE/CHILD(REN)</u>	<u>EMPLOYEE/FAMILY</u>
GUARDIAN PPO	<input type="checkbox"/> \$ 5.55	<input type="checkbox"/> \$ 7.77	<input type="checkbox"/> \$ 11.10	<input type="checkbox"/> \$ 13.32	<input type="checkbox"/> \$ 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

	<u>EMPLOYEE ONLY</u>	<u>EMPLOYEE/SPOUSE</u>	<u>EMPLOYEE/CHILD(REN)</u>	<u>EMPLOYEE/FAMILY</u>
	<input type="checkbox"/> \$1.81	<input type="checkbox"/> \$3.44	<input type="checkbox"/> \$ 3.62	<input type="checkbox"/> \$ 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 dependents.

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	Spouse's Name _____	DOB _____	Gender _____	Relationship
Employee	100% annual salary	Dependent Name _____	DOB _____	Gender _____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
Spouse	\$5,000	Dependent Name _____	DOB _____	Gender _____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter
Dep/Child(ren)	\$2,500	Dependent Name _____	DOB _____	Gender _____	<input type="checkbox"/> Son <input type="checkbox"/> 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 _____	_____
<input type="checkbox"/> SECONDARY BENEFICIARY or	
<input type="checkbox"/> 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).

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

Annual Salary _____

Payroll Deduction Amount
(employer use only)

Weekly Rate _____

Bi-Weekly Rate _____

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 benefits, 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