2026 Health Plan & HSA Enrollment Form

Employee Name: _____

Last 4 of Social Security No: _____

Enrollment Type	
○ New Hire	○ Qualified Life Event

Medical - BCBS of Texas	Dental - BCBS of TX	Vision - VSP Vision Care
○ High Deductible 1 (HSA Eligible) ○ High Deductible 2 (HSA Eligible) ○ 80/20 (Healthcare FSA Eligible) ○ Copay (Healthcare FSA Eligible) ○ Waive Medical	○ Enroll in Dental ○ Waive Dental	○ Enroll in Vision ○ Waive Vision

A dependent verification must be completed for anyone added to the below section before coverage begins. Do not add yourself to this section.

(A)dd (C)ancel	Cover this dependent for:			Dependent Name	Date of Birth	Social Security Number	Gender	Relation
	Medical	Dental	Vision					
	○	○	○					○ Spouse ○ Child
	○	○	○					○ Spouse ○ Child
	○	○	○					○ Spouse ○ Child
	○	○	○					○ Spouse ○ Child
	○	○	○					○ Spouse ○ Child
	○	○	○					○ Spouse ○ Child

Health Savings Account - Bank of America	
○ Amount Per Pay Period	$
○ Annual Goal Amount	$
○ One-Time Contribution	$
○ I decline to contribute to an HSA	

2026 HSA Maximum Contribution Limits

High Deductible 1

Employee Only - $3,800 **Employee Plus - $7,550**

High Deductible 2

Employee Only - $3,900 **Employee Plus - $7,750**

Employees 55 & Older can contribute $1,000 more to the above amounts

I understand that by signing and submitting this form, I hereby authorize any health care provider, insurance company, the Medical Information Bureau or other organization, institution or person that has any information regarding claims or the facts contained herein to release to claims administrator and all such information. A Photostat copy of this authorization shall be considered as effective and valid as the original. I understand that I have a right to receive a copy of this authorization upon request. I understand that by signing and submitting this form, I acknowledge that the above referenced Employer Plan (The Plan) is entitled to recover from any person or firm legally responsible for my injuries up to the amount of benefits the Plan pays on my claim. I will not release any responsible party from liability without the Plan's written approval. I agree to reimburse The Plan to the extent of the amount paid on claims under any non-occupational benefit provision under any Worker's Compensation law or similar legislation.

I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my election(s) above, with the "tax protected" funds being transferred into my Health Savings Account (HSA). I understand that I can make changes to this election if needed during the calendar year. I also understand that this election ceases at the end of each calendar year and a new enrollment form must be submitted for each new plan year.

My signature below affirms that all information and statements, provided on this form, are full, complete and true to the best of my knowledge. I understand that any misrepresentation of a material fact on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable. **I further authorize payroll deductions for selected benefits.**

Signature: _____ Date: _____

Short-Term Disability & Life Insurance Enrollment Form

Employee Name: _____ Last 4 of Social Security No: _____

Short Term Disability

○ Enroll in Short-Term Disability ○ Waive Short-Term Disability

Premiums can be calculated on WEC-Cares.com. Late enrollees will only be able to apply for coverage during Open Enrollment or a Qualifying Life Event.

Voluntary Employee Life/AD&D (Enrolling in this benefit will add coverage to the Basic Life Insurance you are already enrolled in)

○ Coverage Requested $ _____ (must be in increments of $10,000)

○ Waive Voluntary Employee Life/AD&D

Premiums can be calculated on WEC-Cares.com. Guaranteed issue for new hires is $200,000 and maximum coverage is $500,000 or 5X base salary. Evidence of Insurability may be required for some enrollments. Age reduction will apply once employee turns 65(see Benefit Guide for more information).

Voluntary Spouse Life/AD&D (Must be enrolled in Voluntary Employee Life to elect this coverage)

○ Coverage Requested $ _____ (must be in increments of $5,000)

○ Waive Voluntary Spouse Life/AD&D

Premiums can be calculated on WEC-Cares.com. Guaranteed issue at time of hire is $50,000. Maximum coverage is $200,000. Evidence of Insurability may be required for some enrollments. Age reduction will apply once spouse turns 65(see Benefit Guide for more information).

Voluntary Child Life/AD&D (Must be enrolled in Voluntary Employee Life to elect this coverage)

○ $2,500 - $0.17 biweekly ○ $5,000 - $0.33 biweekly ○ $7,500 - $0.49 biweekly ○ $10,000 - $0.65 biweekly

(Premiums cover all enrolled dependents)

○ Waive Voluntary Child

Dependent Name	Date of Birth	Social Security Number	Relationship

Spouse/Child Life

○ $10,000 - $1.01 biweekly (Premiums cover all enrolled dependents)

○ Waive Voluntary Spouse/Child

Dependent Name	Date of Birth	Social Security Number	Relationship

My signature below affirms that all information and statements, provided on this form, are full, complete and true to the best of my knowledge. I understand that any misrepresentation of a material fact on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable. **I further authorize payroll deductions for selected benefits.**

Signature: _____ Date: _____

Critical Illness, Hospital and Accident Insurance Enrollment Form

Employee Name: _____ Last 4 of Social Security No: _____

Critical Illness

Employee Coverage: ○ $10,000 ○ $20,000 ○ $30,000 ○ Waive

Spouse Coverage (100% of Employee coverage): ○ Cover ○ Do Not Cover

Spouse Name (if electing spouse coverage)	Date of Birth	Social Security Number

Children under 26 are automatically covered at 50% of Employee's coverage. Premiums can be found on WEC-Cares.com

Primary Beneficiary	Date of Birth	Social Security Number	Relationship	Percent
Secondary Beneficiary	**Date of Birth**	**Social Security Number**	**Relationship**	**Percent**

Hospital Insurance

○ Emp Only($6.36) ○ Emp+Spouse($17.53) ○ Emp+Children($9.90) ○ Emp+Family($21.06) ○ Waive

Spouse Name (if electing spouse coverage)	Date of Birth	Social Security Number

Primary Beneficiary	Date of Birth	Social Security Number	Relationship	Percent
Secondary Beneficiary	**Date of Birth**	**Social Security Number**	**Relationship**	**Percent**

Accident Insurance

○ Emp Only($3.74) ○ Emp+Spouse($6.82) ○ Emp+Children($8.94) ○ Emp+Family($12.02) ○ Waive

Spouse Name (if electing spouse coverage)	Date of Birth	Social Security Number

Primary Beneficiary	Date of Birth	Social Security Number	Relationship	Percent
Secondary Beneficiary	**Date of Birth**	**Social Security Number**	**Relationship**	**Percent**

I understand that my coverage may be subject to limitations, exclusions and terminations as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change. **Coverage is only guaranteed during your initial enrollment.**

Signature: _____ Date: _____

Life Insurance Beneficiary Form

Employee Name: _____ Last 4 of Social Security No: _____

Basic Life Insurance

Primary Beneficiaries (At least one beneficary is required in this section)

Beneficiary Name	Percent (must TOTAL 100%)	Date of Birth	Social Security Number	Relationship

Secondary Beneficiaries

Beneficiary Name	Percent (must TOTAL 100%)	Date of Birth	Social Security Number	Relationship

Voluntary Life Insurance

Primary Beneficiaries

Beneficiary Name	Percent (must TOTAL 100%)	Date of Birth	Social Security Number	Relationship

Secondary Beneficiaries

Beneficiary Name	Percent (must TOTAL 100%)	Date of Birth	Social Security Number	Relationship

The above basic life and optional life beneficiary designations replace any previous designations I have elected. I understand that if I have elected optional life and have not designated an optional life beneficiary that the company basic life beneficiary designated above will automatically be in force for the optional life.

Signature: _____ Date: _____

Bank of America

Enrollment Form: Flexible Spending Account(s)

GENERAL INFORMATION

Employee Name:_____ Social Security Number: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

E-mail Address: _____

Date of Birth (MM/DD/YYYY):_____ Date of Hire (MM/DD/YYYY): _____

Plan Start Date:_____ **Plan End Date:** 12/31/2026

Benefit	Per Pay Period	# Pay Periods	Annual Election
Healthcare FSA	**$**		**$**
Dependent Care FSA	**$**		**$**

Healthcare FSA Limit: $3,400 *Dependent Care FSA Limit: $7,500*

My pay schedule is: ☐ Weekly ☒ Biweekly ☐ Semimonthly ☐ Monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects me or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

☐ I hereby elect to participate in the Flexible Spending Account.
☐ I hereby elect NOT to participate in the Flexible Spending Account.

_____ _____

Employee Signature Date