2025 BENEFITS ENROLLMENT FORM

EDGEWOOD PROPERTIES
EXCELLENCE IN LIVING

A. EMPLOYEE INFORMATION (PLEASE PRINT NEATLY)

First Name	Last Name	Date of Birth	
Street Address/Unit #	**City**	**State**	**Zip**
Social Security #	**Date of Hire**	**Earnings Per Pay Period**	

Position	Department	Pay Type	Gender
		☐ Hourly ☐ Salary	☐ Male ☐ Female

Please mark your coverage choices carefully. If you are already enrolled in benefits, and do not wish to make any changes, you do not need to complete a form. If you are currently enrolled in any benefits for which you would like to waive coverage, you must fill out a form, and select the option to waive coverage.

B. MEDICAL PLAN OPTION

All costs are per pay period (weekly). Please check (✓) one box.
Medical Coverage (includes Prescription Drug, Dental, and Vision)

	CIGNA OAPIN	CIGNA OAP
Employee Only	☐ $66.65	☐ $105.84
Employee + Spouse	☐ $213.39	☐ $312.03
Employee + Children	☐ $167.91	☐ $251.48
Family	☐ $325.43	☐ $465.59

☐ **I WAIVE Medical Coverage due to:**

☐ Cost ☐ Spouse Coverage ☐ Coverage through government ☐ Other Coverage _____

C. DENTAL PLAN

All costs are per pay period (weekly). Please check (✓) one box.
Dental Coverage Only

	DENTAL PLAN
Employee Only	☐ $7.26
Employee + Spouse	☐ $14.68
Employee + Children	☐ $16.19
Family	☐ $23.87

☐ **I WAIVE Medical Coverage due to:**

☐ Cost ☐ Spouse Coverage ☐ Coverage through government

FORM CONTINUED ON NEXT PAGE

D. DEPENDENT INFORMATION

(Indicate dependents that you want covered by your medical plan)

LAST NAME, FIRST NAME, MI	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER	STUDENT
		/ /		☐ Male ☐ Female	☐ Yes ☐ No
		/ /		☐ Male ☐ Female	☐ Yes ☐ No
		/ /		☐ Male ☐ Female	☐ Yes ☐ No
		/ /		☐ Male ☐ Female	☐ Yes ☐ No
		/ /		☐ Male ☐ Female	☐ Yes ☐ No

E. LIFE AND AD&D INSURANCE (COMPANY PAID)

GROUP TERM LIFE INSURANCE REQUESTED (EMPLOYEE ONLY)	CHECK BENEFITS REQUESTED	COVERAGE REQUESTED
Basic Term Life Insurance	☑	1 x Salary up to $100,000
Basic Accidental Death & Dismemberment (AD&D)	☑	1 x Salary up to $100,000

F. LIFE AND AD&D INSURANCE BENEFICIARY DESIGNATION

Please indicate your beneficiary designation for your Basic Life and AD&D Insurance benefits. You may indicate a Primary and Contingent Beneficiary. New enrollees need to submit their applications within 31 days. Evidence of Insurability is required with applications submitted after 31 days or for more than the guaranteed issue amount.

BENEFICIARY TYPE	BENEFICIARY NAME	BENEFICIARY ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFIT
Primary						
Contingent						

FORM CONTINUED ON NEXT PAGE

G. SUPPLEMENTARY LIFE AND AD&D INSURANCE (EMPLOYEE PAID)

SUPPLEMENTARY LIFE INSURANCE COVERAGE REQUESTED (EMPLOYEE ONLY)	CHECK BENEFITS REQUESTED	COVERAGE AMOUNT REQUESTED
Supplementary Employee Term Life and AD&D	☐	
Supplementary Spousal Term Life and AD&D	☐	
Supplementary Children Term Life and AD&D	☐	

H. SUPPLEMENTAL LIFE AND AD&D RATES (EMPLOYEE/SPOUSE)

AGE	EMPLOYEE/SPOUSE RATE MONTHLY PER $1,000
< 20	$0.10
20-24	$0.10
25-29	$0.10
30-34	$0.13
35-39	$0.17
40-44	$0.19
45-49	$0.30
50-54	$0.54
55-59	$0.87
60-64	$1.24
65-69	$2.30
70+	$3.97

H. SUPPLEMENTAL LIFE AND AD&D RATES (CHILD)

AGE	CHILD RATE MONTHLY PER $1,000
< 26	$1.37

I. SUPPLEMENTARY LIFE AND AD&D INSURANCE (SPOUSE)

Please fill out the below if you elected supplementary spousal life and AD&D. Evidence of Insurability is required with applications submitted after 31 days or for more than the guaranteed issue amount.

Spouse Name

Spouse Date of Birth

Spouse Address

Spouse Social Security #

Beneficiary Name

Beneficiary Date of Birth

Beneficiary Address

Beneficiary Social Security #

Beneficiary Relationship

% of Benefit

FORM CONTINUED ON NEXT PAGE

I. SUPPLEMENTARY LIFE AND AD&D INSURANCE (CHILD)

Please fill out the below if you elected supplementary child life and AD&D. Evidence of Insurability is required with applications submitted after 31 days or for more than the guaranteed issue amount.

Child Name	Child Date of Birth

Child Address

Child Social Security #

Beneficiary Name	Beneficiary Date of Birth

Beneficiary Address

Beneficiary Social Security #	Beneficiary Relationship	% of Benefit

I acknowledge that the above represents my enrollment choices. I understand that by signing this form, I am waiving or authorizing payroll deductions for any required contributions for the coverage(s) selected above. I understand that my pre-tax elections cannot be changed or cancelled during the plan year until a future open enrollment period or a qualified status change occurs. Further, I understand that if I am declining enrollment for myself or my eligible dependents including my spouse because of other insurance coverage, I may in the future be able to enroll myself or my dependents in the above plan(s) provided that I request enrollment within 30 days after my (our) coverage ends. If I do not enroll within 30 days of the loss of insurance coverage, my eligible dependents and I will not be permitted to enroll until the next Annual Enrollment period. In addition, if I have a change in status, I may be able to enroll myself and my dependents provide that I request enrollment within 30 days after the change in status effective date. I represent to the best of my knowledge and belief, all statements and answers entered into this application are true, complete, and correct. I understand that omissions or misrepresentations with respect to the information provided may result in my coverage being void and that I will be responsible for reimbursement or all claims paid for myself or my dependents during an ineligible period.

EMPLOYEE SIGNATURE

Signature	Date

END OF FORM