

Complete this form IF you selected OPTION C

Benefit Options Election Form

EMPLOYEE NAME

CLIENT NAME

You must be a full-time (25+hours) employee to be eligible for benefits. Seasonal, part-time, contract and temp employees are not eligible. Please check the section for the benefit and type of coverage you plan to enroll in. The attached applications for each benefit **MUST BE COMPLETED**. Additional Applications may be required. If you do not complete the appropriate application, you are not enrolled. Return this form and all applications either by mail to Simple HR or Fax: (850) 650-9936, or *contact Benefits if you have any questions at 1-850-650-9935. Remember that not all benefits are available at each worksite location. Please log on to www.simplehrbenefits.com for more detailed information for each benefit plan description.*

ENROLLMENT OPTIONS OR CHANGES (Please complete the appropriate applications)

Employee Only
with spouse
with children
with family
N/A

Please select the type of coverage for each benefit (if applicable). You must still complete a separate application for each benefit option you select. You can download the applications and review more benefits information at www.simplehrbenefits.com

GUARDIAN DENTAL and VISION (VSP) INSURANCE BENEFIT

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | YES, I would like to enroll in dental or make changes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NO, I'm not interested in Guardian Dental |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | YES, I would like to enroll in vision or make changes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NO, I'm not interested in Guardian Vision (VSP) |

SYMETRA DEFINED BENEFIT PLAN

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | YES, I would like to enroll or make changes |
| <input type="checkbox"/> | <input type="checkbox"/> | NO, I'm not interested in Symetra Benefits |

ALLSTATE SUPPLEMENTAL INSURANCE PRODUCTS

Disability Hospital Indemnity Cancer and Specified Disease Heart and Stroke

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | YES, I would like to enroll or make changes |
| <input type="checkbox"/> | <input type="checkbox"/> | NO, I'm not interested in Allstate Supplemental Insurance |

IDENTITY THEFT SHIELD AND PREPAID LEGAL

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | YES, I would like to enroll or make changes |
| <input type="checkbox"/> | <input type="checkbox"/> | NO, I'm not interested in Identity Theft Shield and/or Prepaid Legal |

SIMPLEPAY PAY CARD *(check with your employer for availability)*

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | YES, I would like to enroll |
| <input type="checkbox"/> | <input type="checkbox"/> | NO, I'm not interested in the SimplePay Pay Card |

ELECTION / DECLINATION ACKNOWLEDGEMENT - READ VERY CAREFULLY!

I understand that 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 there is a change in family status, employment, or other reasons as outlined by the IRS rules for the Section 125 Plan. I understand I must complete an enrollment application for each benefit that I elect coverage. I understand and agree that I am fully responsible at all times for any benefit premiums for which I have authorized and such premiums will be deducted from my wages when due.

Signature: _____ DATE: _____