



Employee Election Form

March 1, 2024 - February 28, 2025

Hire Date

Employee Name:

Dental Principal

Network	Principal Dental PPO	
Preventive Services	Covered @ 100%	Deductible
Basic Services	Covered @ 80% after Deductible	\$50 (maximum 3 per Family)
Major Services	Covered @ 50% after Deductible	Annual Maximum
Orthodontics	Not Covered	\$1500 per Covered Person - Annual Rollover benefit \$375
Cost per Pay Period (52)		
Employee Only	<input type="checkbox"/>	\$0.00
Employee/Spouse	<input type="checkbox"/>	\$5.11
Employee/Child(ren)	<input type="checkbox"/>	\$8.01
Family	<input type="checkbox"/>	\$14.08
<input type="checkbox"/> DECLINE DENTAL COVERAGE		

Vision Principal

Network	VSP	Frequency
Eye Examination	\$10 Copay	All vision benefits are available once every 12 months except the Fames Benefit. It is payable once every 24 months in lieu of contacts.
Lenses	\$25 Copay	
Frames	\$150 Allowance	
Contacts (in lieu of glasses)	\$150 Allowance	
Cost per Pay Period (52)		
Employee Only	<input type="checkbox"/>	\$0.00
Employee/Spouse	<input type="checkbox"/>	\$1.02
Employee/Child(ren)	<input type="checkbox"/>	\$1.27
Family	<input type="checkbox"/>	\$2.54
<input type="checkbox"/> DECLINE VISION COVERAGE		

Accident Principal

Pays a cash benefit for sustained injuries on and off the job		
Benefit varies based on the type and severity. Please refer to the benefits payable for the full summary.		
Wellness screening	\$50	
Cost per Pay Period (52)		
Employee Only	<input type="checkbox"/>	\$2.65
Employee/Spouse	<input type="checkbox"/>	\$4.05
Employee/Child(ren)	<input type="checkbox"/>	\$4.52
Family	<input type="checkbox"/>	\$6.94
<input type="checkbox"/> DECLINE ACCIDENT COVERAGE		

This is a Benefit Overview - For full plan information please refer to the applicable Benefit Summary