USE INK ONLY

GROUP INSURANCE ENROLLMENT FORM

Health, Dental, Vision, Short-Term Disability & Voluntary Term Life Plans

EMPLOYEE PERSONAL INFORMATION

Last _____ First _____ MI ____ SSN _____ Occupation/Craft _____

Date of Birth ____/____/____ Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Separated, Divorced

Mailing Address _____ City/State/Zip _____

Date Hired Full Time ____/____/____ Tel # (_____)_____ Personal Email (Required) _____

MEDICAL & PHARMACY PLAN

PLAN I (Traditional Plan)

Level of Coverage	Premium
Employee Only	☐ $48.00 / Week
Employee + One Dependent	☐ $99.00 / Week
Employee + Family	☐ $136.00 / Week

PLAN II (High Deductible Plan)

Level of Coverage	Premium
Employee Only	☐ $18.00 / Week
Employee + One Dependent	☐ $55.00 / Week
Employee + Family	☐ $78.00 / Week

BENEFICIARY DESIGNATION FOR GROUP LIFE WITH MEDICAL

I hereby direct payment of any death benefit under the Plan to the beneficiary listed below. Unless otherwise provided, if more than one beneficiary is designated in any one class, each beneficiary in the same class shall share equally.

First Name _____ MI _____ Last Name _____ Relationship _____

VOLUNTARY DENTAL PLAN

Level of Coverage	Premium	
Employee Only	☐ $5.41 / Week	☐ Do Not Want Dental
Employee + Family	☐ $12.97 / Week	

VOLUNTARY VISION PLAN

Level of Coverage	Premium	
Employee Only	☐ $1.41 / Week	☐ Do Not Want Vision
Employee + One	☐ $2.70 / Week	
Employee + Family	☐ $4.59 / Week	

COMPLETE IF DEPENDENT COVERAGE IS REQUESTED ***Complete Spousal Coverage Affidavit on the next page if electing spousal coverage***

Relationship	First & Last Name	Enroll Dependent In	Date of Birth	SSN	Sex
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F

Do you or your dependents currently have other health insurance? ☐ Yes ☐ No
If yes, give name of policyholder, policy #, name of insured, insurance company, effective date, and if applicable, termination date.

AGREEMENT

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and herby authorize my employer to deduct from my earnings the required contributions. All contributions will be deducted on a pre-tax basis, except for short-term disability and term life premiums.

_____ _____
Employee Signature Date

WAIVER OF COVERAGE

I have decided not to apply for coverage offered as checked below. I understand that the Affordable Care Act requires individuals to have health insurance through their employer or some other source such as government sponsored healthcare exchange or be subject to a penalty. I understand that Cajun's health plan meets the minimum value standard and is intended to be affordable.

MEDICAL ☐ Self ☐ Dependents DENTAL ☐ Self ☐ Dependents
VISION ☐ Self ☐ Dependents LIFE ☐ Self ☐ Dependents

I decline such coverage because:

☐ My spouse is employed by _____ and is insured for similar health benefits.

☐ My children have health coverage under (plan or policy name) _____

☐ Other Reasons (explain) _____

_____ _____ _____ _____
Employee Signature Print Name Contact Telephone Number Date

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement.

EMAIL Forms to: benefits@cajunusa.com OR Mail Enrollment Form to: PO Box 104, Baton Rouge, LA 70821, ATTN: Benefits Dept.

SPOUSAL COVERAGE AFFIDAVIT

All employees enrolling a spouse in Cajun's health insurance plan must verify their spouses' eligibility under the plan. A spouse is not an eligible dependent if the spouse is currently employed and his or her employer offers health insurance.

If your spouse is currently on Cajun's Health Insurance Plan and is no longer eligible due to eligibility of coverage under his or her employer's health insurance plan, your spouse should notify his or her Human Resources department to inform them that they will be losing their coverage under the Cajun Health Insurance Plan. This qualifies as a "Life Event" and gives them the opportunity to enroll in their employer's plan regardless of the open enrollment period as long as they enroll within 30 days of losing their coverage. Cajun will furnish you with a notice for your spouse's employer upon receipt of this affidavit.

This form must be returned to the Benefits Department with your enrollment to ensure that your spouse is eligible to be covered by the health insurance plan.

VERIFICATION OF SPOUSE ELIGIBILITY

In order to confirm that your spouse is eligible to be covered as a dependent on the Cajun medical plan, please complete the following questions.

Is your spouse employed either full-time or part-time? Full Time [ ] Part Time [ ] No [ ]

If yes, does your spouse's employer offer medical benefits to their employees? If no, you must notify the Benefits Department if your spouse becomes eligible for insurance coverage due to his or her employment status change. Yes [ ] No [ ] N / A [ ]

I hereby certify that I understand that if my spouse has medical coverage available to them through their own employer, they are not eligible to be covered as a dependent on the Cajun Health Insurance Plan.

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge.

I understand that any misrepresentation or falsification of information I have provided above will permit the Cajun Health Insurance Plan to terminate the spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. I further understand that I must report any changes in my spouse's employment status to the Benefit's Department.

In addition, willful provision of false information may result in disciplinary action up to and including termination of employment.

_____ _____ _____

Print your name here | Social Security # of Employee | Contact Telephone Number

_____ _____

Employee signature | Date signed

PARTICIPATION AGREEMENT FOR HEALTH SAVINGS AND FLEXIBLE SPENDING (CAFETERIA PLAN) ACCOUNTS

Option I: Cafeteria/Healthcare Flexible Spending Account (FSA) Agreement

_____: I elect to contribute $_____ (before taxes) per pay period, which is $ _____ per plan year, to fund my account for reimbursement of qualified healthcare expenses not covered under my health and other insurance plans, up to an annual specified by my Plan

Spouse's or Dependents full name for 2nd Take Care debit card: _____

Option II: Dependent Daycare Reimbursement Account Agreement

_____: I elect to contribute $_____ (before taxes) per pay period, which is $ _____ per plan year, for funding of qualified dependent daycare expenses. (Maximum amount per calendar year is the lesser of; (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation, or (3) ½ of your total annual compensation. If you are single, the maximum amount is $5,000.

Option III: Health Savings Account (HSA) Contributions & Limited Flexible Spending Account

☐ YES I elect to contribute $_____ (before taxes) per pay period, to fund my Health Savings Account (HSA)

I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period, to fund my Limited Health FSA for qualified expenses. I understand that my Health Flexible Spending Account will be a **"limited health flexible spending account"** for reimbursement of **dental, vision and preventative care** only up to the maximum of my employer plan.

Healthcare FSA and Limited Use FSA maximum is $2,600 per year.

PLEASE READ CAREFULLY

HEALTH CARE FLEXIBLE SPENDING DEBIT CARD AGREEMENT: By signing and using the TakeCare Benefits card I agree to the terms of the Funds Transfer Disclosure Statement ("Agreement") received with the card. Use of the card is authorized for qualified healthcare expenses only as outlined in my Plan Documents. I certify that expenses will not be reimbursed under any other health plan coverage. Upon request, I will immediately submit any other documentation requested by the OMNI Group, the Plan Administrator. Failure to submit such documentation may result in: (1) my obligation to repay the amount to my employer; (2) immediate suspension or revocation of the Card, and/or (3) taxable, payroll deductions by my employer of the ineligible expenses.
PARTICIPATION / WAIVER: My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may not change my annual election except in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description. If I voluntarily waive coverage under Option IV, I understand the benefits of participating in the plan and that if I should later desire to participate I will have to wait until the next Plan Year unless I experience an official change in family status.

_____ _____

Employee signature | Date signed

_____ _____

Print Name | Social Security # of Employee

VOLUNTARY SHORT TERM DISABILITY - EMPLOYEE ONLY (Choose One)

☐ Do Not Want Short-Term Disability ☐ Yes I Want Short-Term Disability. Weekly cost is the amount of weekly benefit divided by 10 * $0.14

VOLUNTARY TERM LIFE INSURANCE (Choose One)

NOTE: You must elect at least as much insurance on yourself in order to elect insurance for a spouse or child.

Employee Benefit Election (Volume of Life Insurance): ☐ Do Not Want Voluntary Term Life Insurance

☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000
☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000

Spouse Benefit Election (Include Spouse Info Below if Elected):
☐ $10,000 ☐ $25,000 ☐ $50,000

Child Benefit Election: (Include Child Info Below if Elected):
☐ $10,000

BENEFICIARY DESIGNATION FOR VOLUNTARY TERM LIFE

I hereby direct payment of any death benefit under the Plan to the beneficiary listed below. Unless otherwise provided, if more than one beneficiary is designated in any one class, each beneficiary in the same class shall share equally.

Name	**Percentage**	**Relationship**
Address	**Type:** ☐ Primary OR ☐ Contingent	**SSN**
Name	**Percentage**	**Relationship**
Address	**Type:** ☐ Primary OR ☐ Contingent	**SSN**
Name	**Percentage**	**Relationship**
Address	**Type:** ☐ Primary OR ☐ Contingent	**SSN**
Name	**Percentage**	**Relationship**
Address	**Type:** ☐ Primary OR ☐ Contingent	**SSN**

ELIGIBLE DEPENDENT INFORMATION

Complete if you elected Voluntary Term Life benefits for your spouse or children

Spouse's Name	**Birth Date**	☐ M or ☐ F	**SSN**
Name(s) of Child(ren)	**Birth Date**	☐ M or ☐ F	**SSN**
	Birth Date	☐ M or ☐ F	**SSN**
	Birth Date	☐ M or ☐ F	**SSN**
	Birth Date	☐ M or ☐ F	**SSN**
	Birth Date	☐ M or ☐ F	**SSN**

AGREEMENT

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and hereby authorize my employer to deduct from my earnings the required contributions. Short-term disability and voluntary term life contributions will be deducted on a post-tax basis. I understand that voluntary term life coverage is portable and convertible. Portability must be applied for within 60 days of losing coverage, and conversion must be applied for within 31 days of losing coverage by visiting www.Principal.com/Cajun or calling 800-986-3343.

Employee Signature _____ Social Security # of Employee _____ Date _____

Print Name _____ Email Address (REQUIRED) _____