

# Benefits Election Form

Use this form to indicate the benefits you wish to elect. Some benefits require you to complete a paper form. If this is required, the forms are included in your employment packet and must be filled out in completion, even if you have provided the information on this form.

## 1. Employee Information

**Benefits Effective:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (Last, First, MI)		Date of Birth (mm/dd/yyyy)	Social Security Number	
Home Address			City, State, ZIP	
Personal Email Address		Phone	Hire Date	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender (M/F)	Hours Per Week: <input type="checkbox"/> FT or <input type="checkbox"/> PT	Annual Salary	
Title			MUW ID#	
<b>Select One:</b> <input type="checkbox"/> Initial/New Hire <input type="checkbox"/> Status Change (Add or Drop Dependents) <input type="checkbox"/> Drop/Refuse Coverage				



*You MUST complete a separate form for the State & School Employees' Health and/or Life Insurance, whether you elect or waive coverage. A separate form for Renasant Bank Health Savings Accounts is also required for those who are eligible to enroll. You must also sign the acknowledgement on page 6.*

**Complete this form to elect OR waive the following benefits.**

- ◆ Guardian Dental, Vision, Life or Accident ◆ Reliance Standard Disability or Life ◆ ManhattanLife Cancer or Critical Illness ◆ Unreimbursed Medical Spending ◆ Dependent Care Spending

## 2. Persons To Be Enrolled/Dependent Information

**Only complete this section if you are enrolling spouse and/or dependents.** Employee must be enrolled to cover dependents, where applicable. Include the names of the all dependents you wish to enroll in coverage (other than State Health). Additional information may be required for non-standard dependents.

Last Name	First Name	Social Security Number	Relationship	Gender (M/F)	D.O.B. (mm/dd/yyyy)

Employee Name: \_\_\_\_\_

### 3. Guardian Dental (Pre-tax)

<b>Check only one box to enroll or select to waive coverage.</b>			
<input type="checkbox"/> Employee Only	<input type="checkbox"/> EE & Spouse	<input type="checkbox"/> EE & Dependent/Child(ren)	<input type="checkbox"/> EE, Spouse & Dependent/Child(ren)
\$45.90 monthly premium	\$87.96 monthly premium	\$108.96 monthly premium	\$153.85 monthly premium
<input type="checkbox"/> Waive Coverage			

### 4. Guardian Vision (Davis) (Pre-tax)

<b>Check only one box to enroll or select to waive coverage.</b>			
<input type="checkbox"/> Employee Only	<input type="checkbox"/> EE & Spouse	<input type="checkbox"/> EE & Dependent/Child(ren)	<input type="checkbox"/> EE, Spouse & Dependent/Child(ren)
\$10.72 monthly premium	\$16.67 monthly premium	\$17.28 monthly premium	\$25.02 monthly premium
<input type="checkbox"/> Waive Coverage			

### 5. Guardian Life Insurance (Post-tax)

<b>Check coverage options or select to waive coverage.</b>		
Employee must enroll in this coverage to enroll spouse and/or dependent/child(ren). This benefit requires you to complete beneficiary information on page 5. Evidence of Insurability is required if the elected amount exceeds the Guarantee Issue.		
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Add Spouse Coverage	<input type="checkbox"/> Add Dependent/Child(ren) Coverage
Policy Amount	Policy Amount (not more than 50% of EE amount)	Policy Amount (not more than 10% of EE amount)
\$ _____	\$ _____	\$ _____
Monthly Premium	Monthly Premium	Monthly Premium
\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> I Do Not Want	<input type="checkbox"/> I Do Not Want
<b>Total <u>Guardian Life Insurance</u> Premium \$ _____</b>		

Employee Name: \_\_\_\_\_

## 6. Guardian Accident (Pre-tax)

<b><i>Check only one box to enroll or select to waive coverage.</i></b> This benefit requires you to complete beneficiary information on page 5			
<input type="checkbox"/> Employee Only  \$13.28 monthly premium	<input type="checkbox"/> EE & Spouse  \$21.56 monthly premium	<input type="checkbox"/> EE & Dependent/Child(ren)  \$21.65 monthly premium	<input type="checkbox"/> Family  \$29.93 monthly premium
<input type="checkbox"/> Waive Coverage			

## 7. Reliance Standard Disability (Post-tax)

<b><i>Employee Only Coverage</i></b> <b><i>Check only one box to enroll or select to waive coverage.</i></b>				
<input type="checkbox"/> Option 1 0/3 day EP  Benefit Amount \$ _____  Monthly Premium \$ _____	<input type="checkbox"/> Option 2 14 day EP  Benefit Amount \$ _____  Monthly Premium \$ _____	<input type="checkbox"/> Option 3 30 day EP  Benefit Amount \$ _____  Monthly Premium \$ _____	<input type="checkbox"/> Option 4 90 day EP  Benefit Amount \$ _____  Monthly Premium \$ _____	<input type="checkbox"/> Option 5 180 day EP  Benefit Amount \$ _____  Monthly Premium \$ _____
<input type="checkbox"/> Waive Coverage				

## 8. Reliance Standard Life Insurance (Post-tax)

<b><i>Check coverage options or select to waive coverage.</i></b> Employee must enroll in this coverage to enroll spouse and/or dependent/child(ren). This benefit requires you to complete beneficiary information on page 5.				
Employee Coverage <u>Age</u> <input type="checkbox"/> <39 <input type="checkbox"/> 40+	<u><b>\$20K</b></u> <input type="checkbox"/> \$4.20 <input type="checkbox"/> \$6.80	<u><b>\$30K</b></u> <input type="checkbox"/> \$6.30 <input type="checkbox"/> \$10.20	<u><b>\$50K</b></u> <input type="checkbox"/> \$10.50 <input type="checkbox"/> \$17.00	<u><b>\$100K</b></u> <input type="checkbox"/> \$21.00 <input type="checkbox"/> \$34.00
<input type="checkbox"/> Waive Coverage				
Add Spouse Coverage <u>Age</u> <input type="checkbox"/> <39 <input type="checkbox"/> 40+	<u><b>\$10K</b></u> <input type="checkbox"/> \$2.10 <input type="checkbox"/> \$3.40	<u><b>\$20K</b></u> <input type="checkbox"/> \$4.20 <input type="checkbox"/> \$6.80	<u><b>\$30K</b></u> <input type="checkbox"/> \$6.30 <input type="checkbox"/> \$10.20	<u><b>\$40K</b></u> <input type="checkbox"/> \$8.40 <input type="checkbox"/> \$13.60
<input type="checkbox"/> I Do Not Want				
Add Children <u><b>\$10K</b></u> for <input type="checkbox"/> \$2.60			<input type="checkbox"/> I Do Not Want	
<b>Total <u>Reliance Standard Life Insurance</u> Premium \$ _____</b>				

Employee Name: \_\_\_\_\_

## 9. ManhattanLife Critical Illness (Post-tax)

<p align="center"><b><i>Check only one box to enroll or select to waive coverage.</i></b></p> <p align="center">This benefit requires you to complete beneficiary information on page 5.</p>			
<p><b>NON-TOBACCO, Employee Age _____</b></p>			
<input type="checkbox"/> Employee Only Benefit Amount \$ _____ Monthly Premium \$ _____	<input type="checkbox"/> EE & Spouse Benefit Amount \$ _____ Monthly Premium \$ _____	<input type="checkbox"/> EE & Dependent/Child(ren) Benefit Amount \$ _____ Monthly Premium \$ _____	<input type="checkbox"/> Family Benefit Amount \$ _____ Monthly Premium \$ _____
<p><b>TOBACCO, Employee Age _____</b></p>			
<input type="checkbox"/> Employee Only Benefit Amount \$ _____ Monthly Premium \$ _____	<input type="checkbox"/> EE & Spouse Benefit Amount \$ _____ Monthly Premium \$ _____	<input type="checkbox"/> EE & Dependent/Child(ren) Benefit Amount \$ _____ Monthly Premium \$ _____	<input type="checkbox"/> Family Benefit Amount \$ _____ Monthly Premium \$ _____
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> I Do Not Want	<input type="checkbox"/> I Do Not Want	<input type="checkbox"/> I Do Not Want

## 10. ManhattanLife Cancer (Pre-tax)

<p align="center"><b><i>Check only one box to enroll or select to waive coverage.</i></b></p>			
<input type="checkbox"/> Employee Only <input type="checkbox"/> Low \$24.87 <input type="checkbox"/> Mid \$27.00	<input type="checkbox"/> EE & Spouse <input type="checkbox"/> Low \$51.48 <input type="checkbox"/> Mid \$55.79	<input type="checkbox"/> EE & Dependent/Child(ren) <input type="checkbox"/> Low \$33.56 <input type="checkbox"/> Mid \$36.18	<input type="checkbox"/> Employee & Family <input type="checkbox"/> Low \$60.14 <input type="checkbox"/> Mid \$64.97
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> I Do Not Want	<input type="checkbox"/> I Do Not Want	<input type="checkbox"/> I Do Not Want

Employee Name: \_\_\_\_\_

## 11. Flexible Spending Accounts (Pre-tax)

<b>Check coverage options to enroll or select to waive coverage.</b>	
<input type="checkbox"/> Unreimbursed Medical Expenses  Annual Limit: \$3,300  Monthly Amount \$ _____	<input type="checkbox"/> Dependent Care Expenses  Annual Limit: \$7,500 (2026) (\$3,750 if married filing separate)  Monthly Amount \$ _____
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage

## 12. Beneficiary Information for: Guardian Life/Accident, ManhattanLife Critical Illness, Reliance Standard Life

<b>Primary Beneficiaries</b>			
If more than one, percentages must total 100%. If additional space is needed, attach a separate sheet of paper which includes all of the following information. Be sure to sign and date the additional sheet.			
Name (Beneficiary 1)	Social Security Number	Percentage	Benefit
			<input type="checkbox"/> Guardian Acc/Life <input type="checkbox"/> ManhattanLife <input type="checkbox"/> Reliance Standard
Address/City/State/Zip	Date of Birth (mm/dd/yyyy)	Relationship	Phone
Name (Beneficiary 2)	Social Security Number	Percentage	Benefit
			<input type="checkbox"/> Guardian Acc/Life <input type="checkbox"/> ManhattanLife <input type="checkbox"/> Reliance Standard
Address/City/State/Zip	Date of Birth (mm/dd/yyyy)	Relationship	Phone
Name (Contingent Beneficiary)	Social Security Number	Percentage	Benefit
			<input type="checkbox"/> Guardian Acc/Life <input type="checkbox"/> ManhattanLife <input type="checkbox"/> Reliance Standard
Address/City/State/Zip	Date of Birth (mm/dd/yyyy)	Relationship	Phone

Employee Name: \_\_\_\_\_

### 13. Health History for Guardian Life and/or Reliance Standard Life

In the last 6 months have you or any of your dependents (only answer for spouse and dependents if electing this coverage) received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS); or any other Chronic Condition?

☐ Yes, I have.    ☐ No, I haven't.    ☐ Yes, my spouse has.    ☐ No, my spouse hasn't.

☐ Yes, my dependent child(ren) have.    ☐ No, my dependent child(ren) haven't.

**An Evidence of Insurability form must be completed for any person with a "Yes" answer.**

### 14. State & School Employees' Health and/or Life Insurance, HSA (Pre-tax) Acknowledgement

State Health Insurance Election: ☐ Enroll    ☐ Waive    Premium Amount \$\_\_\_\_\_ (for HR)

State Life Insurance Election:    ☐ Enroll    ☐ Waive    Premium Amount \$\_\_\_\_\_ (for HR)

**Health/Life requires that you complete a separate form, whether you elect or waive coverage.**

HSA Election: ☐ Not Eligible    ☐ Enroll    ☐ Waive    Premium Amount \$\_\_\_\_\_ (for HR)

**HSA requires that you complete a separate form to enroll and you must be enrolled in a HDHP.**

Enrollment means you agree to the terms as stated in section 15 below as acknowledged by your signature.

### 15. Employee Confirmation and Acknowledgement

- I hereby apply for myself and any dependents listed on this Election Form for the coverage indicated.
- If accepted, I understand that coverage is subject to the exclusions and all other provisions contained in the benefit plan.
- I understand that my salary will be reduced by the amount(s) shown for the benefit(s) I have elected as indicated by pre-tax or post-tax.
- I have carefully read this Election Form and understand it is the employee responsibility to read and understand the benefit(s) elected.
- I understand after the initial enrollment period of 30 days from date of hire, the Internal Revenue Code regulations only allow you to cancel or change your pre-tax coverage elections during the Open Enrollment period, unless you experience a qualified family status change as defined under the Code. Your benefit change must be consistent with your status change. You have 60 days to make corresponding changes; however, there could be payroll implications if you wait the full 60 days. Contact Human Resources as soon as possible to complete all applicable forms.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_