



HAWAII Abhe & Svoboda, Inc.

2024 – 2025 Benefits Enrollment

Employee Information <i>(Please print clearly)</i>					
First Name:	M.I.	Last Name:	Social Security #:	Telephone:	
Address:			City:	State:	Zip:
Birth Date:	Gender:	Marital Status:	Email Address:		

Dependent Information <i>(Please enter dependent information and check the benefits(s) in which you wish to enroll each dependent)</i>										
Name (First, M.I., Last)	Sex	DOB	SP, DP or CH	Social Security #	Medical	Dental	Vision	Dep. Life	Critical Illness	Accident
Spouse/Domestic Partner:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical Insurance – UHA Health Insurance			
<i>Group # 211857</i>			
	ASI/Trust Pays	EE Pays	(Please Check One)
Employee Only (Mandatory for Prevailing Wage Employees)	\$ 486.02	\$ 0.00	<input type="checkbox"/>
Employee + Spouse/Domestic Partner	\$ 486.02	\$ 569.31	<input type="checkbox"/>
Employee + Child(ren)	\$ 486.02	\$ 462.20	<input type="checkbox"/>
Family	\$ 486.02	\$ 972.65	<input type="checkbox"/>
<i>By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.</i>			

Dental Insurance – Delta Dental			
<i>Group # 127237</i>			
	ASI/Trust Pays	EE Pays	(Please Check One)
Employee Only (Mandatory for Prevailing Wage Employees)	\$ 19.25	\$ 19.25	<input type="checkbox"/>
Employee + Spouse/Domestic Partner	\$ 24.50	\$ 59.50	<input type="checkbox"/>
Employee + Child(ren)	\$ 31.20	\$ 62.80	<input type="checkbox"/>
Family	\$ 39.70	\$ 99.30	<input type="checkbox"/>
<i>By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.</i>			

Employee Name:

Vision Insurance – EyeMed Group # 1011257		
	RATES	(Please CHECK One)
Employee Only	\$ 8.14	<input type="checkbox"/>
Employee + Spouse/Domestic Partner	\$ 15.46	<input type="checkbox"/>
Employee + Child(ren)	\$ 16.27	<input type="checkbox"/>
Family	\$ 23.92	<input type="checkbox"/>
By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.		

Basic Life, AD&D – The Standard Group # 171322	
Provided by Abhe & Svoboda, Inc.	
Your Employee Basic Life Insurance and Accidental Death & Dismemberment Insurance premiums are paid by Abhe & Svoboda, Inc. Enrollment is automatic for those employees who meet the eligibility requirements. The benefits are as follows: <p style="text-align: center;">Employee Basic Life: \$10,000 Employee AD&D Benefit: \$10,000</p> <p style="text-align: center;"><i>NOTE: Life and AD&D benefits reduce by 35% at age 65 and to 50% at age 70.</i> <i>All coverage cancels at retirement.</i></p>	

Voluntary Life Insurance Rates – The Standard Group # 171322												
Monthly Cost for Each \$1,000 of Employee & Spouse/Domestic Partner* Life Insurance Coverage												
Age	< 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Life	.050	.050	.080	.090	.130	.220	.360	.590	.780	1.270	2.140	2.140
Dependent Children	\$10,000 benefit – cost is \$1.40 per month and covers all eligible dependent children.											
NOTE:												
<ul style="list-style-type: none"> Employee coverage is required to elect coverage for spouse/domestic partner or children. Spouse/domestic partner rate is based on employee's age. Voluntary Life benefits reduce by 35% at age 65 and to 50% at age 70. All coverage cancels at retirement. Underwriting is required if coverage was previously waived. 												
<p>EXAMPLE: John is 46 years old at the time of application or renewal elects \$50,000 of Voluntary Life.</p> <p style="text-align: center;"><u>\$ Amount of Coverage ÷ 1,000 x \$ Unit Cost from Above = \$ Employee Monthly Cost</u></p> <p style="text-align: center;"><u>\$50,000 ÷ 1,000 x .22 = \$11.00 monthly cost</u></p>												

Employee Name: _____

Voluntary Life – The Standard <i>Group # 171322</i>		Requested Amount Spouse/domestic partner no greater than 50% of EE	Premium Rate <i>(For Office Use Only)</i>
Employee Life		\$ _____	\$ _____
Spouse/domestic partner Life		\$ _____	\$ _____
Child Life		\$10,000	\$1.40 All Children
NEW HIRES ONLY: Medical History Statement Form is required for Amounts over \$150,000 for employees	NEW HIRES ONLY: Medical History Statement Form is required for Amounts over \$50,000 for spouse/domestic partner	Life Insurance Premiums will be paid on an after-tax basis, per IRS regulations	

Beneficiary Information – Updates ONLY

The Employee signing below names the following person’s as primary beneficiary(ies) for any payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. This designation applies to Life and AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. The Employee understands that he or she has the right to change this designation at any time.

Beneficiary Name (First, M.I., Last)	Relationship	Allocation (%)	Social Security #	Phone # & Address
Contingent Beneficiary	Relationship	Allocation (%)	Social Security #	Phone # & Address

Voluntary Accident – The Standard

<i>Group # 171322</i>	RATES	(Please CHECK One)
Employee Only	\$ 3.70	<input type="checkbox"/>
Employee + Spouse/Domestic Partner	\$ 5.76	<input type="checkbox"/>
Employee + Child(ren)	\$ 7.16	<input type="checkbox"/>
Family	\$ 11.17	<input type="checkbox"/>

By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.


Employee Name: _____

Voluntary Critical Illness – The Standard		
Group # 171322		
<i>(Please CHECK One)</i>		
Employee Only Requested Amount	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000
Spouse/Domestic Partner Request Amount (Cannot Exceed 50% of Employee Requested Amount)	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Note: Children are automatically covered at 50% of your coverage amount.		
By NOT electing any of the above coverages, it is assumed you are WAIVING coverage.		

Critical Illness Attained Age Monthly Premium - Employee						
	19-29	30-39	40-49	50-59	60-69	70+
\$10,000	\$3.20	\$4.60	\$8.80	\$17.70	\$32.30	\$77.80
\$20,000	\$6.40	\$9.20	\$17.60	\$35.40	\$64.60	\$155.60

Critical Illness Attained Age Monthly Premium - Spouse						
	19-29	30-39	40-49	50-59	60-69	70+
\$5,000	\$1.60	\$2.30	\$4.40	\$8.85	\$16.15	\$38.90
\$10,000	\$3.20	\$4.60	\$8.80	\$17.70	\$32.30	\$77.80

I understand the benefits and limitations of the various plans and I authorize Abhe & Svoboda, Inc. to make the necessary deductions from my pay, based on my choices. I further understand my decisions are in effect for the plan year and no changes can be made prior to the next open enrollment unless a change in status occurs. A change in status is defined by Federal law, but may include events such as, but not limited to, marriage, divorce, termination or commencement of employment for you, your spouse/domestic partner or dependents, etc. If I experience a qualifying change in status, I understand that I have 30 days to make an election change and this change must be consistent with the change in status. I understand that my deduction amount will change if my coverage costs change.

 **Abhe & Svoboda, Inc. conducts periodic audits to ensure that dependents enrolled in the plan meet the eligibility criteria. Any misrepresentation or falsification of information regarding eligibility for coverage or benefits may be considered fraud and could result in (i) termination of your benefits, (ii) termination of your employment, and (iii) reimbursement to Abhe & Svoboda, Inc. of benefit that were improperly obtained.**

I represent that the statements contained herein are true and complete, to the best of my knowledge and belief.

Employee Signature _____ Date _____

Employee Printed Name _____

FOR OFFICE USE ONLY:

For Human Resources Purpose Only

<input type="checkbox"/> New Hire	<input type="checkbox"/> Early Retiree	<input type="checkbox"/> Marriage	<input type="checkbox"/> COBRA
<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Divorce/Legal separation	<input type="checkbox"/> Termination/Reduction in work hours	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Death	<input type="checkbox"/> Special Enrollment – Date: _____	
<input type="checkbox"/> Retiree	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Other: _____	

Date of event: _____

Employer Signature _____ Date _____