BENEFIT *Your Life*

2026 BENEFIT ENROLLMENT FORM *CHANGE IN STATUS*

IMPORTANT: RETURN TO BENEFITS VIA My Locker WITHIN 31 DAYS OF THE STATUS CHANGE EVENT

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYEE ID _____

DOB _____

DATE OF HIRE _____

DATE OF STATUS CHANGE _____

Indicate your Plan and Coverage Change for each of the programs listed below.
NOTE: If you are currently enrolled, you CANNOT change plans.

HEALTH BENEFIT OPTIONS (Please make a selection from below or check here ☐ to Waive this coverage.)

Cigna Traditional PPO

☐ Teammate ($97 per pay) ☐ Teammate & Spouse ($225 per pay) ☐ Teammate & Child(ren) ($169 per pay) ☐ Family ($334 per pay)

☐ Teammate & Domestic Partner ($225 per pay–$128 of which will be after tax)

☐ Family ($334 per pay–$237 of which will be after tax for DP & DP's child(ren) or $165 for Teammate, DP, and child(ren))

Cigna Core HRA (Health Reimbursement Account) Plan

☐ Teammate ($51 per pay) ☐ Teammate & Spouse ($97 per pay) ☐ Teammate & Child(ren) ($82 per pay) ☐ Family ($143 per pay)

☐ Teammate & Domestic Partner ($97 per pay–$46 of which will be after tax)

☐ Family ($143 per pay–$92 of which will be after tax for DP & DP's child(ren) or $61 for Teammate, DP, and child(ren))

Cigna Buy-up HSA (Health Savings Account) Plan

☐ Teammate ($67 per pay) ☐ Teammate & Spouse ($174 per pay) ☐ Teammate & Child(ren) ($138 per pay) ☐ Family ($190 per pay)

☐ Teammate & Domestic Partner ($174 per pay–$107 of which will be after tax)

☐ Family ($190 per pay–$123 of which will be after tax for DP & DP's child(ren) or $52 for Teammate, DP, and child(ren))

Cigna Base HSA (Health Savings Account) Plan

☐ Teammate ($26 per pay) ☐ Teammate & Spouse ($77 per pay) ☐ Teammate & Child(ren) ($51 per pay) ☐ Family ($102 per pay)

☐ Teammate & Domestic Partner ($77 per pay–$51 of which will be after tax)

☐ Family ($102 per pay–$76 of which will be after tax for DP & DP's child(ren) or $51 for Teammate, DP, and child(ren))

DENTAL BENEFIT OPTIONS (Please make a selection from below or check here ☐ to Waive this coverage.)

United Concordia Base Plan

☐ Teammate ($6 per pay) ☐ Teammate & Spouse ($10 per pay) ☐ Teammate & Child(ren) ($11 per pay) ☐ Family ($20 per pay)

☐ Teammate & Domestic Partner ($10 per pay–$4 of which will be after tax)

☐ Family ($20 per pay)–$14 of which will be after tax for DP & DP's child(ren) or $9 for Teammate, DP, and child(ren))

United Concordia Buy-up Plan

☐ Teammate ($9 per pay) ☐ Teammate & Spouse ($15 per pay) ☐ Teammate & Child(ren) ($17 per pay) ☐ Family ($31 per pay)

☐ Teammate & Domestic Partner ($15 per pay–$6 of which will be after tax)

☐ Family ($31 per pay–$22 of which will be after tax for DP & DP's child(ren) or $14 for Teammate, DP, and child(ren))

Continued on Page 2

VISION BENEFIT OPTIONS (Please make a selection from below or check here ☐ to Waive this coverage.)

VSP Base Plan

☐ Teammate (21¢ per pay) ☐ Teammate & Spouse (44¢ per pay) ☐ Teammate & Child(ren) (44¢ per pay) ☐ Family (44¢ per pay)

☐ Teammate & Domestic Partner (44¢ per pay—23¢ of which will be after tax)

☐ Family (44¢ per pay—23¢ of which will be after tax for DP & DP's child(ren) or $0 for Teammate, DP, and child(ren))

VSP Buy-up Plan

☐ Teammate ($3.78 per pay) ☐ Teammate & Spouse ($8.10 per pay) ☐ Teammate & Child(ren) ($8.10 per pay) ☐ Family ($8.10 per pay)

☐ Teammate & Domestic Partner ($8.10 per pay—$4.32 of which will be after tax)

☐ Family ($8.10 per pay—$4.32 of which will be after tax for DP & DP's child(ren) or $0 for Teammate, DP, and child(ren))

HEALTH SAVINGS ACCOUNT

IMPORTANT NOTES: You may ONLY contribute to an HSA Account if you are selecting the Buy-Up HSA or Base HSA Plans. If selecting the Buy-Up HSA or Base HSA Plans, you are NOT eligible to participate in the Health Care Flexible Spending Accounts.

Contribution Per Pay (min. $0) Your Annual Election (min. $0; max $4,400-individ/$8,750-family)

NOTE: Teammates over age 55 can elect an additional $1,000 catch-up contribution

_____ or ☐ Waive

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Contribution Per Pay (min. $52; max $3,400)

_____ or ☐ Waive

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Contribution Per Pay (min. $52; max $7,500)

_____ or ☐ Waive

DEPENDENT ENROLLMENT

Name	SSN	DOB	Relationship	Gender	Medical	Dental	Vision	Dep. Life
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

TEAMMATE SUPPLEMENTAL LIFE INSURANCE

Coverage Amount (1x – 7x salary, rounded up to next thousand & max. $1 million; proof of good health required for coverage of $400,000+)

_____ or ☐ Waive

TEAMMATE SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT

Coverage Amount (1x – 7x salary, rounded up to next thousand & max. $1 million)

_____ or ☐ Waive

SPOUSE/DOMESTIC PARTNER SUPPLEMENTAL LIFE INSURANCE

Coverage Amount (10k, 20k, 50k)

☐ 10k @ 69¢ per pay ☐ 20k @ $1.38 per pay ☐ 50k @ $3.45 per pay or ☐ Waive

DEPENDENT CHILD (REN) SUPPLEMENTAL LIFE INSURANCE

Coverage Amount (10k, 20k)

☐ 10k @ 46¢ per pay ☐ 20k @ 92¢ per pay or ☐ Waive

Continued on Page 3

BASIC LIFE INSURANCE AND AD&D

The following Beneficiary Designation revokes and replaces any prior designations.

Beneficiary Name	Relationship	Primary?	Secondary?	% of Proceeds

(FULL-TIME HOURLY ONLY) VOLUNTARY LONG-TERM DISABILITY

☐ Teammate Enroll (Please make a selection or ☐ Waive this coverage.)

SUPPLEMENTAL ACCIDENT INSURANCE (Please make a selection or ☐ Waive this coverage.)

☐ Teammate ($1.61 per pay) ☐ Teammate & Spouse ($2.92 per pay) ☐ Teammate & Child(ren) ($3.73 per pay) ☐ Family ($5.05 per pay)

SUPPLEMENTAL CRITICAL ILLNESS INSURANCE (Please make a selection or ☐ Waive this coverage.)

(Teammate and Spouse/Partner Ages & Coverage Amounts must be entered using Chart below)

☐ Teammate (Non-Tob.) ☐ Teammate (Tob.) ☐ Spouse/Partner (Non-Tob.) ☐ Spouse/Partner (Tob.) ☐ Child(ren)

Teammate Age _____ Teammate Amount _____ S/P Age _____ S/P Amount _____ Child(ren) Amount _____

SUPPLEMENTAL HOSPITAL CARE INSURANCE (Please make a selection or ☐ Waive this coverage.)

☐ Teammate ($2.61 per pay) ☐ Teammate & Spouse ($6.96 per pay) ☐ Teammate & Child(ren) ($4.24 per pay) ☐ Family ($8.58 per pay)

Summary of Critical Illness Rates

NON-TOBACCO – Teammate					
AGES	$5,000	$10,000	$20,000	$25,000	$30,000
< 29	$.64	$1.28	$2.56	$3.20	$3.84
30 – 39	$.78	$1.56	$3.12	$3.90	$4.68
40 – 49	$1.17	$2.34	$4.68	$5.85	$7.02
50 – 59	$2.10	$4.20	$8.40	$10.50	$12.60
60 – 69	$3.50	$7.00	$14.00	$17.50	$21.00
70 – 79	$5.88	$11.76	$23.52	$29.40	$35.28
80 – 89	$9.28	$18.56	$37.12	$46.40	$55.68
90 +	$9.28	$18.56	$37.12	$46.40	$55.68

NON-TOBACCO – Spouse / Partner					
AGES	$5,000	$10,000	$20,000	$25,000	$30,000
< 29	$.51	$1.02	$2.04	$2.55	$3.06
30 – 39	$.72	$1.44	$2.88	$3.60	$4.32
40 – 49	$1.19	$2.38	$4.76	$5.95	$7.14
50 – 59	$2.16	$4.32	$8.64	$10.80	$12.96
60 – 69	$3.54	$7.08	$14.16	$17.70	$21.24
70 – 79	$6.28	$12.56	$25.12	$31.40	$37.68
80 – 89	$10.25	$20.50	$41.00	$51.25	$61.50
90 +	$10.25	$20.50	$41.00	$51.25	$61.50

TOBACCO – Teammate					
AGES	$5,000	$10,000	$20,000	$25,000	$30,000
< 29	$.75	$1.50	$3.00	$3.75	$4.50
30 – 39	$1.07	$2.14	$4.28	$5.35	$6.42
40 – 49	$1.92	$3.84	$7.68	$9.60	$11.52
50 – 59	$3.63	$7.26	$14.52	$18.15	$21.78
60 – 69	$5.78	$11.56	$23.12	$28.90	$34.68
70 – 79	$8.57	$17.14	$34.28	$42.85	$51.42
80 – 89	$11.74	$23.48	$46.96	$58.70	$70.44
90 +	$11.74	$23.48	$46.96	$58.70	$70.44

TOBACCO – Spouse / Partner					
AGES	$5,000	$10,000	$20,000	$25,000	$30,000
< 29	$.64	$1.28	$2.56	$3.20	$3.84
30 – 39	$1.07	$2.14	$4.28	$5.35	$6.42
40 – 49	$2.08	$4.16	$8.32	$10.40	$12.48
50 – 59	$3.93	$7.86	$15.72	$19.65	$23.58
60 – 69	$6.15	$12.30	$24.60	$30.75	$36.90
70 – 79	$9.96	$19.92	$39.84	$49.80	$59.76
80 – 89	$14.43	$28.86	$57.72	$72.15	$86.58
90 +	$14.43	$28.86	$57.72	$72.15	$86.58

Children				
$2,500	$5,000	$10,000	$12,500	$15,000
$.36	$.72	$1.44	$1.80	$2.16

REASON FOR CHANGE IN STATUS

☐ Marriage/Divorce/Legal separation

☐ My dependent and/or I had a gain or loss of coverage through another group health plan

☐ Birth, adoption, or placement of adoption or foster care of a child

☐ Commencing or returning from an unpaid leave of absence

☐ Death of a spouse or dependent

Continued on Page 4

- Dependent child losing eligibility for health care coverage (due to 26 age limit)
- Dissolution of domestic partnership
- Significant changes in health coverage premiums attributable to my spouse's employment

REQUIRED SUPPORTING DOCUMENTATION (MUST accompany this form)

EVENT	DOCUMENTATION (copies are acceptable)
Marriage	Marriage Certificate
Legal Separation or Divorce	Court Document or Divorce Decree
Birth, Adoption, or placement for adoption or foster care of a child	Footprints, Hospital Documentation, Birth Certificate* (Do NOT wait for newborn's Social Security Number), Court Document
Death of a spouse or dependent	Certified Death Certificate
Termination or commencement of employment of spouse	A letter from employer indicating coverage start date or coverage end date
Significant changes in health coverage rates that are attributable to your spouse's employment	Previous and current health coverage and premium rates with a letter from the employer
Dissolution of domestic partnership	Notarized affidavit
Losing eligibility for health care coverage due to age 26 limit	A letter from parent's employer indicating coverage end date and coverages lost

By signing this Enrollment Form, I acknowledge and agree to the following:

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I understand that after I enroll, the benefit plan carrier may need to obtain Confidential Information. I also understand the carrier may not provide this Confidential Information to others. "Confidential Information" means, with respect to me and any covered dependents, any personal, medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.

1. Any person or entity having Confidential Information has my permission to provide this Confidential Information upon request to:
   - The benefit plan carrier
   - Any participating provider of the carrier
   - Any other provider or entity performing a service

   for the purpose of plan administration, the performance of any health care network program or operations, or to assess the quality of and access to health care services and supplies.
2. The benefit plan carrier has my permission to give any Confidential Information to the person, company or entity when it determines that such disclosure is necessary or appropriate for:
   - The administration of the plan
   - The performance of the programs or operations
   - Assessing quality and accessibility of services and supplies
   - Reporting to third parties involved in plan administration
3. I am making this authorization for myself and as the agent or representative of my spouse and my dependents. I understand that it will remain in effect until I send a written notice revoking it to the benefit plan administrator or for such a shorter period as required by law. Until revoked, this Authorization may be relied upon by the benefit plan administrator, carrier and other parties.
4. I authorize payment of any and all benefits payable under the plan to any licensed provider of care who treats me and/or my covered dependents.

DISCLAIMER

- I understand that contributions for medical, dental, and vision plans are made on a before-tax basis, except for Domestic Partners and their child(ren), which are made on an after-tax basis.
- I certify that the statements made herein are true and accurate.
- I understand that benefit elections cannot be changed during the calendar year, except as the result of and consistent with a Family or Employment Status Change.
- I acknowledge that my benefits elections will not become effective until contributions have been deducted from my pay.

EMPLOYEE SIGNATURE

Signature: _____ **Date:** _____

CHANGE IN STATUS SUBMISSION INSTRUCTIONS:

1A) Scan this document and submit online through Workday via My Locker (Benefits Change in Status request). If you do not have access to DSGN, email this document to benefits@dcsg.com. IMPORTANT: If you are sending this from your personal email account, we recommend that you password protect this form and your documentation to protect Social Security Numbers and other personal information. You will need to contact Benefits to give them the password to open your email attachments. Contact Benefits if you need assistance.

OR 1B) Fax to 1.724.227.1082

2) Verify receipt of documentation (1.800.690.7655 x3012, option 5)

Contact Benefits at 1.800.690.7655, ext. 3012 (option 5) with any questions regarding status changes, benefits, or documentation you need to submit to support your coverage request. It is your responsibility to contact Benefits to verify receipt of your documentation.