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PB_Insert_Feeder: 000000
PB_Server_ID: 9
PB_Job_ID:
PB_PlanetCode_ServiceCode: 40
PB_Mailing_ID:

OPEN ENROLLMENT NOTIFICATION

Date of Notice: 2/12/2021

Member Name: Gary Sample - Account # - 0910395400
Employer Name: Sample Companies Group, Inc.- 90091

To Gary Sample and Eligible Covered Dependents (if applicable) - 0910395400:

Sample Companies Group, Inc. is currently offering open enrollment for plan changes. You may make changes such as choosing different health plan options or adding/deleting coverage for family members for the new plan year, which begins on 01/01/2021.

Enrollments are subject to verification of eligibility on elected health plans and may include rate or plan changes by your plan sponsor. Please use the enclosed form to make any changes to your current coverage and return it to WageWorks.

It is very important that the premium payments for your current coverage are paid through the end of the plan year or you will not be eligible for continuation coverage in the upcoming plan year. **Premium payments must be made even if you do not receive an invoice.** Following your initial premium payment, which is due 45 days after the date of your election, monthly premiums are due on the first day of each month and will be returned if postmarked 30 days after the payment is due. Claims and prescriptions cannot be paid until your payment is received.

Premium payments are considered paid on the date you mail them (*as evidenced by your postmark date*). If your premium payment is made by check, and your check is returned because of insufficient funds, your premium is treated as unpaid. You must make full payment within the required time period, including a grace period, to prevent cancellation. ***If you submit any premium payment after the required postmark date, or if you submit any premium payment and you are otherwise ineligible for coverage, these payments will be refunded to you. Acceptance of premium payments by WageWorks is not an indication that coverage is in force. If your coverage is canceled for non-payment of premium, you cannot reinstate it.***

If you have any questions, please contact WageWorks at 888-678-4881.

*Please fill out and return the form on the following pages.
For faster service, fax to 866-450-5641 or enroll online at mybenefits.wageworks.com.*

DEADLINE for CHANGES: If you wish to make changes to your coverage during open enrollment, they must be made within 31 days from the date the notice was mailed. If you do not wish to make any changes**, no action is necessary.

****Please review Section A: Description of Changes to Current Plans to determine whether changes are mandatory.**

RATES: Please note the rates provided on this Open Enrollment form reflect the standard COBRA rates for all participants. If there are any special circumstances that apply to your COBRA continuation coverage such as extended benefits due to disability or severance, your monthly premiums will be reflected on the first invoice for the start of the new rate period. That invoice will reflect the premium that applies to you.

ONLINE OPEN ENROLLMENT: You may submit any enrollment changes via the web at mybenefits.wageworks.com which will allow you to then view your new monthly premium. Should you make your election online you will not be required to mail in your changes.

Section A. Description of Changes to Current Plans

Please review plan options listed in Section B below.

Section B. Group Health Plan Component(s)

Check the box next to the monthly cost of the group health plan component(s) you are selecting. NOTE: If you are making any changes to your current coverage you **must** select each plan you intend to carry in the new plan year. Please complete Sections C and D to indicate which individual(s) you wish to cover on the plans selected below.

Dental - UHC Dental PPO 1500 Plan

Child Only <input type="checkbox"/> \$27.47	Employee Only <input type="checkbox"/> \$27.47	Spouse Only <input type="checkbox"/> \$27.47	Children Only <input type="checkbox"/> \$53.62	Employee + Child <input type="checkbox"/> \$53.62	Employee + Children <input type="checkbox"/> \$53.62
Spouse + Child <input type="checkbox"/> \$53.62	Spouse + Children <input type="checkbox"/> \$53.62	Employee + Spouse <input type="checkbox"/> \$69.24	Family <input type="checkbox"/> \$95.39		

Dental - UHC Dental PPO 2500 Plan

Child Only <input type="checkbox"/> \$30.08	Employee Only <input type="checkbox"/> \$30.08	Spouse Only <input type="checkbox"/> \$30.08	Children Only <input type="checkbox"/> \$58.73	Employee + Child <input type="checkbox"/> \$58.73	Employee + Children <input type="checkbox"/> \$58.73
Spouse + Child <input type="checkbox"/> \$58.73	Spouse + Children <input type="checkbox"/> \$58.73	Employee + Spouse <input type="checkbox"/> \$75.84	Family <input type="checkbox"/> \$104.48		

Check here to Waive Dental Coverage

Medical - UHC HDHP 3000 Medical Plan

Child Only <input type="checkbox"/> \$421.26	Employee Only <input type="checkbox"/> \$421.26	Spouse Only <input type="checkbox"/> \$421.26	Children Only <input type="checkbox"/> \$846.73	Employee + Child <input type="checkbox"/> \$846.73	Employee + Children <input type="checkbox"/> \$846.73
Spouse + Child <input type="checkbox"/> \$846.73	Spouse + Children <input type="checkbox"/> \$846.73	Employee + Spouse <input type="checkbox"/> \$981.53	Family <input type="checkbox"/> \$1,284.83		

Medical - UHC HDHP 4000 Medical Plan

Child Only <input type="checkbox"/> \$396.49	Employee Only <input type="checkbox"/> \$396.49	Spouse Only <input type="checkbox"/> \$396.49	Children Only <input type="checkbox"/> \$796.96	Employee + Child <input type="checkbox"/> \$796.96	Employee + Children <input type="checkbox"/> \$796.96
Spouse + Child <input type="checkbox"/> \$796.96	Spouse + Children <input type="checkbox"/> \$796.96	Employee + Spouse <input type="checkbox"/> \$923.83	Family <input type="checkbox"/> \$1,209.31		

Medical - UHC PPO 2500 Medical Plan

Child Only <input type="checkbox"/> \$556.11	Employee Only <input type="checkbox"/> \$556.11	Spouse Only <input type="checkbox"/> \$556.11	Children Only <input type="checkbox"/> \$1,117.80	Employee + Child <input type="checkbox"/> \$1,117.80	Employee + Children <input type="checkbox"/> \$1,117.80
Spouse + Child <input type="checkbox"/> \$1,117.80	Spouse + Children <input type="checkbox"/> \$1,117.80	Employee + Spouse <input type="checkbox"/> \$1,295.74	Family <input type="checkbox"/> \$1,696.14		

Check here to Waive Medical Coverage

Vision - UHC Vision Plan

Child Only <input type="checkbox"/> \$7.27	Employee Only <input type="checkbox"/> \$7.27	Spouse Only <input type="checkbox"/> \$7.27	Children Only <input type="checkbox"/> \$13.82	Employee + Child <input type="checkbox"/> \$13.82	Employee + Children <input type="checkbox"/> \$13.82
Spouse + Child <input type="checkbox"/> \$13.82	Spouse + Children <input type="checkbox"/> \$13.82	Employee + Spouse <input type="checkbox"/> \$15.27	Family <input type="checkbox"/> \$21.82		

Check here to Waive Vision Coverage

Section C. Current Member Information

Please verify our records are accurate and make changes as necessary. You **MUST** select the plan type for each individual you intend to cover.

Member Name	Relationship	Gender
Sample, Gary	Self	M
<input type="checkbox"/> Cafeteria Plan	<input type="checkbox"/> Dental	<input type="checkbox"/> Medical
<input type="checkbox"/> Vision		
<input type="checkbox"/> Check Here to Delete Coverage		

Section D. Add Dependents

Check the box next to the dependent you are enrolling on your account. Also select the type of coverage. Each dependent added is subject to eligibility verification prior to receiving coverage. Please note that any dependent(s) added to your coverage may increase your total monthly premium.

Dependent Name	Relationship	Birth Date	SSN	Gender
<input type="checkbox"/> _____ Cafeteria Plan Dental Medical Vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> _____ Cafeteria Plan Dental Medical Vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> _____ Cafeteria Plan Dental Medical Vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> _____ Cafeteria Plan Dental Medical Vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> _____ Cafeteria Plan Dental Medical Vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____	_____

Applicant's Authorization and Agreement

- I elect the coverage checked above in Section B under the Sample Companies Group, Inc. group health plan;
- I verify that all information provided is correct; and
- I understand that if I do not make the appropriate election(s) on this form, I cannot make changes for the upcoming plan year.

Applicant's Signature: _____

Date: _____

Print Name: _____

If you wish to change your coverage, your response is required.

For faster service, fax to 866-450-5641 or enroll online at mybenefits.wageworks.com.
Or mail completed form to: WageWorks, Inc. at P.O. Box 223684 Dallas, TX 75222-3684.