1/1/2025 to 12/31/2025 Plan Year

BENEFITS ELECTION FORM

Highly Compensated Employees | www.pinebeltbenefits.com

1. EMPLOYEE INFORMATION

Please provide all requested information

Full Name: | Social Security Number: | Benefit Effective Date:

Address: | Date of Birth: | Gender: | Date of Hire:

City: | State: | Zip: | Daytime Phone Number:

Email Address:

2. MEDICAL/PRESCRIPTION (CVS) COVERAGE - Please check (✓) one box (NOTE: Employee contributions shown below are WEEKLY deductions)

You must return the Non-Tobacco User Certification form to receive the below deductions. Failure to return the form will result in an increase of $23.07/pay for Tobacco Users.

Carrier/ Plan	Waive Coverage	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
Meritain EPO/CVS Caremark	☐	☐ $210.24	☐ $303.41	☐ $403.95	☐ $556.57
Meritain HDHP with HSA/CVS Caremark	☐	☐ $146.71	☐ $201.92	☐ $270.23	☐ $365.29

If waiving coverage, please mark one of the following boxes with "✓"

☐ I am covered under my spouse's employer's plan ☐ I am covered under a plan not provided by an employer ☐ I have no medical coverage

3. DENTAL COVERAGE - Please check (✓) one box (NOTE: Employee contributions shown below are WEEKLY deductions)

Carrier/ Plan	Waive Coverage	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
Delta PPO Plus Premier	☐	☐ $5.16	☐ $14.14	☐ $14.14	☐ $14.14

4. VISION COVERAGE - Please check (✓) one box (NOTE: Employee contributions shown below are WEEKLY deductions)

Carrier/ Plan	Waive Coverage	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
NVA Vision Plan	☐	☐ $1.29	☐ $3.47	☐ $2.57	☐ $5.01

5. DEPENDENT INFORMATION

DEPENDENT FULL NAME	RELATIONSHIP (SPOUSE/CHILD)	DATE OF BIRTH (MM/DD/YY)	SSN	GENDER (M/F)	MEDICAL	DENTAL	Vision

EMPLOYEE AUTHORIZATION

I have received and read the printed material explaining the Pine Belt Enterprises, Inc Benefits Program and my choices under the program. By signing and returning this Election Form I am authorizing the Pine Belt Enterprises, Inc to take the necessary contributions from my salary for the benefits in which I have enrolled and indicated on this form. I understand that these contributions will be taken over each payroll period on a BEFORE-TAX basis unless I indicate that I want my contributions to be made using AFTER-TAX money. I understand that my benefit choices will be irrevocable for the coming Plan Year unless I have a change in family status or elect to have my contributions taken from my pay on an AFTER-TAX BASIS.

PLEASE CHECK THE BOX BELOW ONLY IF YOU WANT YOUR AUTHORIZED CONTRIBUTIONS TO BE MADE ON AN AFTER-TAX BASIS.

☐ I do not want my contributions made on a before-tax basis.

EMPLOYEE SIGNATURE _____ DATE_____

FOR PINE BELT ENTERPRISES, INC. OFFICE USE ONLY

_____/_____/_____/_____

Date Received | Date Processed | Effective Date of Coverage | Authorized Benefits Representative