

1/1/2026 to 12/31/2026 Plan Year

BENEFITS ELECTION FORM

Employees Hired After 3/01/07 | www.pinebeltbeneftes.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	<input type="checkbox"/>	<input type="checkbox"/> \$151.25	<input type="checkbox"/> \$218.30	<input type="checkbox"/> \$296.42	<input type="checkbox"/> \$400.52
Meritain HDHP with HSA/CVS Caremark	<input type="checkbox"/>	<input type="checkbox"/> \$55.89	<input type="checkbox"/> \$121.98	<input type="checkbox"/> \$161.77	<input type="checkbox"/> \$218.75

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	<input type="checkbox"/>	<input type="checkbox"/> \$5.16	<input type="checkbox"/> \$14.14	<input type="checkbox"/> \$14.14	<input type="checkbox"/> \$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	<input type="checkbox"/>	<input type="checkbox"/> \$1.29	<input type="checkbox"/> \$3.47	<input type="checkbox"/> \$2.57	<input type="checkbox"/> \$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