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|  | **SAMCO Capital Markets, Inc.** **Benefits Election Form**Complete, sign and return this form to the Human Resources Department  |
| If you have questions regarding benefits enrollment, please contact Wischmeyer Gallagher at (972) 663-7293. (Dallas-2.GBS.Eligibility@ajg.com)  |
| Benefits elections / changes will begin January 1st and will remain in effect for the entire 2013 Plan Year. Exception: If you experience a qualifying life status change event that affects your benefit eligibility or coverage, you must notify Human Resources within 30 days in order to make changes to your elections. If you do not notify Human Resources to request changes within the 30 day period, no changes will be allowed until the next annual enrollment period on January 1st. |
| **Enrollee Type**  | **Employer Use Only** |
| **Please check the box that applies:**□ New Hire □ Open Enrollment□ Change in Status or Qualifying Event (indicate event below) Event: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Event Date: **\_\_\_** / **\_\_\_** / **\_\_\_\_\_\_** | **Date of Hire: \_\_\_** / **\_\_\_** / **\_\_\_\_\_\_****Effective Date: \_\_\_** / **\_\_\_** / **\_\_\_\_\_\_****Annual Salary: $ \_\_\_\_\_\_\_\_\_\_\_****Division: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Employee Information**  |
| **Employee Name (First)** | **MI** | **Last Name** | **Social Security Number** | **Gender** |
|  |  |  |  | ○ Male ○ Female |
| **Date of Birth (MM/DD/YY)** | **Phone Number** | **E-mail Address** | **Marital Status** |
|  | ( ) |  | ○ Single ○ Married |
| **Street Address** | **Apt #** | **City** | **State** | **Zip** |
|  |  |  |  |  |
| **Dependent Information** Select whether to add or remove each dependent from the benefit plan selected. List additional dependents on a separate sheet of paper and attach it to this form if you need more space. |
| **Change** | **Type of Coverage** | **\*Rel Code** | **First Name Last Name** | **MI** | **SSN** | **Date of Birth** | **M / F** |
| □ Add □ Remove | □ Medical □ Dental □ Vision |  |  |  |  |  |  |
| □ Add □ Remove | □ Medical □ Dental □ Vision |  |  |  |  |  |  |
| □ Add □ Remove | □ Medical □ Dental □ Vision |  |  |  |  |  |  |
| □ Add □ Remove | □ Medical □ Dental □ Vision |  |  |  |  |  |  |
| □ Add □ Remove | □ Medical □ Dental □ Vision |  |  |  |  |  |  |
| \* Please enter the corresponding Relationship Code: Spouse = **SP**; Son = **SON**; Daughter = **DAU** |
| **MEDICAL Administered by Cigna** | **Check Plan Choice and Type of Coverage****Rates indicated are per month.** |
|  | **Type of Coverage** | **Monthly** | **Type of Coverage** | **Monthly** |
| □ HDHP / HSA Plan  | □ Employee Only  | $0.00 | □ Employee + Child(ren)  | $433.17 |
| □ Employee + Spouse  | $537.01 | □ Employee + Family  | $913.33 |
| □ PPO Plan  | □ Employee Only  | $0.00 | □ Employee + Child(ren)  | $513.86 |
| □ Employee + Spouse  | $689.85 | □ Employee + Family  | $1024.68 |
| □ Waive Medical Coverage **(Please mark reason for waiving coverage below)** □ Covered under a spouse □ Covered under Medicaid/Medicare □ Covered under military or retirement plan □ Not covered, too expensive  |
|  |  |
| **Current Medical Coverage Information**Complete this section only if you or any of your dependents have other health coverage **that will not be cancelled** when this coverage becomes effective. |
| **Name of Primary Enrollee:** | **Date of Birth:** | **Group Coverage:**  | **Name and Address of Other Health Company** |
|  |  | ○ Yes ○No  |  |
| Employment Date (if prior coverage was group plan): \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_Effective Date of Other Coverage: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_Group or Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Who Was Covered on the Prior Policy?** (List the names of every individual covered on other policy who will be covered on the new policy as well). |
|  |
| **Medicare Coverage Information**Complete this section only if you or any of your dependents have other health coverage **that will not be cancelled** when this coverage becomes effective. |
| **Name of Primary Enrollee:** | **Medicare HIC# (from ID Card):** | **Reason for Medicare Eligibility** |
|  |  | □ Entitled Age □ Disability and Current Renal Disease □ Entitled Disability □ End-Stage Renal Disease |
| □  **Medicare Part A** | □  **Medicare Part B** | □  **Medicare Part D** |
| Start Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_End Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ | Start Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_End Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ | Start Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_End Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ |
| **DENTAL** **Administered by MetLife** | **Check Plan Choice and Type of Coverage****Rates indicated are per month.** |
|  | **Type of Coverage** | **Monthly** | **Type of Coverage** | **Monthly** |
| □ DHMO  | □ Employee Only  | $4.09 | □ Employee + Child(ren)  | $22.60 |
| □ Employee + Spouse  | $11.39 | □ Employee + Family  | $24.89 |
| □ PPO | □ Employee Only  | $34.95 | □ Employee + Child(ren)  | $93.80 |
| □ Employee + Spouse  | $66.35 | □ Employee + Family  | $120.38 |
| □ Waive Dental Coverage **(Please mark reason for waiving coverage below)** □ Covered under a spouse □ Covered under Medicaid/Medicare □ Covered under military or retirement plan □ Not covered, too expensive  |
| **VISION** **Administered by VSP through Guardian** | **Check Plan Choice and Type of Coverage****Rates indicated are per month.** |
|  | **Type of Coverage** | **Monthly** | **Type of Coverage** | **Monthly** |
| □ Vision | □ Employee Only  | $2.12 | □ Employee + Child(ren)  | $6.68 |
| □ Employee + Spouse  | $7.08 | □ Employee + Family  | $7.17 |
| □ Waive Vision Coverage **(Please mark reason for waiving coverage below)** □ Covered under a spouse □ Covered under Medicaid/Medicare □ Covered under military or retirement plan □ Not covered, too expensive  |
| COMPANY PAID BASIC LIFE AND AD&D *Administered by Sun Life Financial* |
| Basic Life Benefit – 2X Annual Salary up to $500,000 Basic Accidental Death and Dismemberment Benefit - In the event of an accidental death, your benefit is doubled. |

***\*Refer to plan documents for details***

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| **OPTIONAL LIFE AND AD&D Administered by Guardian** |
| **Employee:** $10,000 increments to $500,000  \* Guarantee Issue Amount is $100,000. **Spouse:** $5,000 increments to $250,000 \* Guarantee Issue Amount is $50,000**Child:** Benefit amount flat $10,000 for children ages 14 days to 26 years. \* Guarantee Issue Amount is $10,000.**\***The Guarantee issue amount is only available for new hires. See plan document for complete coverage description. If you are not a new employee or are currently enrolled and want to add or increase your spouse’s coverage amount, you must submit an Evidence of Insurability (EOI) form for approval. | **Check all that apply and enter the amount of coverage in the blanks below.**□ Employee Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Spouse Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Child Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Waive Voluntary Life |
| **Voluntary Life & AD&D Monthly Rate Table per $10,000 of benefit**Both employee and spouse rates are based on the employee’s age |
| Age | < 30 | 30 – 34 | 35 – 39 | 40 – 44 | 45 – 49 | 50 – 54 | 55 – 59 | 60 – 64 | 65 – 69 | 70 + |
| Rate per $10,000 | $0.90 | $1.00 | $1.20 | $1.70 | $2.60 | $3.80 | $6.00 | $9.30 | $14.60 | $14.60 |
| **Optional Dependent Life & AD&D monthly Rate per $1,000 of benefit**The child rate covers **all children** in the family. |
| **Rate per $10,000 per month** | 14 Days – 26 years | **$1.60** |
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| **Calculating Employee and Spouse Voluntary Life and AD&D premiums** | **Employee** | **Spouse** |  |
| STEP 1: Enter the amount of Voluntary Life Coverage you would like to elect for yourself and spouse. |  $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| STEP 2: Divide the amount of Voluntary Life Coverage by $10.000. | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| STEP 3: Using the chart above, enter applicable rate based on your age.  **Both employee and spouse rates are based on the employee’s age.**  | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| STEP 4: Multiply the amount from Step 2 by the rate in Step 3.This is your premium cost ***per month*.** | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **Child Voluntary Life premium** | **Children** |  |
| Dependent Child premium is a flat $1.60 per month for $10,000 | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| **Beneficiary Designation**In accordance with the conditions of the Group Policy, I hereby revoke any previous designations of primary beneficiary(ies) and secondary beneficiary(ies), if any, and designate as primary beneficiary(ies), if any, and contingent beneficiary(ies), if any. In the event of the insured’s death, the following applies to Basic Life and AD&D and Voluntary Life and AD&D amounts unless otherwise noted. |
| **Primary Beneficiary Designation** |
| Beneficiary Full Name (Last, First, Middle Initial) | Relationship | Date of Birth | Address | % of Benefit |
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| Payment will be made in equal shares for all survivors unless otherwise indicated. | 100% |
| **Secondary Beneficiary Designation** In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies**):** |
| Beneficiary Full Name (Last, First, Middle Initial) | Relationship | Date of Birth | Address | % of Benefit |
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| Payment will be made in equal shares for all survivors unless otherwise indicated. | 100% |
| COMPANY PAID LONG TERM DISABILITY *Administered by Sun Life* |
| 60% of average monthly earnings up to $10,000 |
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| **Health Savings Account (HSA) Administered by HSA Bank** |

As an eligible employee, I acknowledge that I understand the benefits, rights, and obligations available to me under the plan. I certify that I am enrolled in a qualified high deductible health insurance plan and am not eligible to receive any benefits under another health plan or general purpose FSA. I also recognize that I am responsible for any documentation, banking fees, etc. associated with my HSA account.I authorize SAMCO Capital Markets, Inc. to deduct the following amount from each paycheck to contribute to my HSA account on a pre-tax basis (please note that the maximum calendar year contribution for “Employee Only” coverage is $3,250 or $6,450 per year for “Employee and Dependent” coverage for 2013.**Employee Contributions**□ I elect an additional HSA contribution of $\_\_\_\_\_\_\_\_\_\_\_ per paycheck. |
| **Flexible Spending Account (FSA) Administered by ADP** |
| **Medical FSA:** Maximum allowable contribution is $2,500 per year Available only to employees not enrolled with a Health Savings Account; to be used for eligible medical, dental and vision expenses. **Dependent Care FSA:** Maximum allowable contribution is $5,000 per year Available to all eligible employees. | **Check all that apply and enter the annual election in the blanks below.**□ Medical FSA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Dependent Care FSA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ I do not wish to participate in a Flexible Spending Account |
| Your medical, dental, and HSA deductions will automatically be deducted on a pre-tax basis unless you indicate your election as after-tax on this form. This reduces your taxable income, saving you money each pay period. By checking below, you indicate that you DO NOT wish deductions to be pre-tax. □ I **DO NOT** wish to have my benefits deducted on a **pre-tax basis**. **I elect to have all deductions taken after-tax.** |
| I have read this form and the other materials given to me about my benefits, and certify the information I have supplied is correct. I understand that misstatements, misrepresentations, or omissions may result in my coverage being canceled as of its effective date. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary procedures up to and including termination. I also understand that any person who knowingly provides false, incomplete or misleading facts or information to any insurer may be found guilty of insurance fraud, which is a crime, and may be subject to both civil and criminal penalties.I understand that the benefit coverage I elect on this form will be in effect for the entire 2012 Plan year unless I experience a qualified status change event which includes marriage, legal separation, divorce, birth, adoption, placement for adoption or change in employment status. Any changes I make must be consistent with the qualified status change event. I understand that if I decline enrollment in a health plan for myself or my dependents (including my spouse) because of other health insurance coverage, that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my other coverage ends. In addition, if I have a new dependent as a result of birth, adoption, or placement of adoption, I must add this dependent within 31 days of such event. I also understand that if I decline enrollment now and have no other health insurance coverage, do not enroll within 31 days of losing my current health insurance coverage, or do not enroll within 31 days of a change in status (31 days if adding a dependent as a result of birth, adoption, or placement of adoption), that I must wait until an annual enrollment period to enroll.Payroll Deduction Authorization: By signing and submitting this enrollment form, I authorize SAMCO Capital Markets, Inc. and/or the affiliates (the “company”) to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I understand that my contributions for the following coverages (if elected) will be deducted pre-tax: medical, dental, and HSA contributions. My contributions for the other coverages that I have elected will be deducted after-tax. I understand that I am liable for these deductions pursuant to such authorization and acknowledge that it is my responsibility to verify that these payroll deductions are correct. Further, I understand that my pay will be deducted for my elections retroactive to my benefits eligibility date. Any administrative error by the company in honoring such payroll deductions, whether unintentional or inadvertent, does not relieve me of this liability. I will notify the SAMCO Capital Markets, Inc. Human Resources Department in writing immediately upon discovering any discrepancy.**Name ( Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |