2024-2025 Chemicals Benefits Enrollment/ Change/Waiver Form

It is very important that you complete every section of this form legibly and thoroughly. If you do not, it may delay or result in NO COVERAGE for you and/or your dependents. This information will be used to enroll and payroll deduct for the coverages elected.

Last Name First Name M.I.	Social Security #	Date of Birth
Telephone #	**Marital Status**	**Gender** (Circle) **Male Female**
Mailing Address:	**City:**	**State / Zip:**
Occupation	**Date of Hire**	

Bundled BCBSNC MEDICAL/Rx, DENTAL & VISION (Semi-Monthly Rate)	
Employee Only	☐ I elect - $50.00
Employee + Spouse	☐ I elect - $250.00
Employee + Child(ren)	☐ I elect - $200.00
Employee + Family	☐ I elect - $400.00
Waive Coverage	☐ I elect to waive all bundled coverages

Dependent Information – Please enter all dependent information below for those being covered under the above bundled benefits package of: **Medical/Rx, Dental & Vision**

Last Name	First Name	Date of Birth	SSN (Required)	Relationship (Circle Spouse or Child)	Gender (Circle)
				Sp. Ch.	**M F**
				Sp. Ch.	**M F**
				Sp. Ch.	**M F**
				Sp. Ch.	**M F**
				Sp. Ch.	**M F**

NEW Voluntary Term Life Benefit Election Write in amount elected amount & Semi-Monthly Deduction Minimum $10,000 Increment for Employee and $5,000 Increments for Spouse & Child(ren)			
Employee	☐ I elect _____	Semi-Monthly Deduction _____	☐ I elect to waive
Spouse	☐ I elect _____	Semi-Monthly Deduction _____	☐ I elect to waive
Child(ren)	☐ I elect _____	Semi-Monthly Deduction _____	☐ I elect to waive

Beneficiary Designation – Must be completed for Employee Life/AD&D Coverage.
(For Dependent Life, the employee is the designated beneficiary by default.)

Base Life Primary Beneficiary:	**Relationship:**	**Percentage (%):**
Base Life Primary Beneficiary:	**Relationship:**	**Percentage (%):**
Base Life Contingent Beneficiary:	**Relationship:**	**Percentage (%):**
Base Life Continent Beneficiary:	**Relationship:**	**Percentage (%):**
Vol Life Primary Beneficiary:	**Relationship:**	**Percentage (%):**
Vol Life Primary Beneficiary:	**Relationship:**	**Percentage (%):**
Vol Life Contingent Beneficiary:	**Relationship:**	**Percentage (%):**
Vol Life Contingent Beneficiary:	**Relationship:**	**Percentage (%):**

Employee Acknowledgment (Medical, Dental and Vision Plans)

AUTHORIZATION

I authorize MetroTech Chemicals to deduct from my paycheck the appropriate (if any) pre-tax and after-tax premiums for the selections I have made. I understand that these selections are required by law to remain in effect for the period of April 1, 2024 through March 31, 2025, unless I experience a Change in Status, also known as a Qualified Life Event. A change in a benefit election must be consistent with the Change in Status/Qualified Life Event, which may include birth, death, divorce, adoption, change in spouse's employment status, change in my own employment status, a dependent losing eligibility due to age. I understand I must notify MetroTech Chemicals of such change in status within 30 days of the change. **If notice is not provided within 30 days of the change, I will NOT be able to make changes to my elections until the next Annual Open Enrollment Period as designated by MetroTech Chemicals.** I understand that my pre-tax payments may affect my Social Security benefits.

I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided or made available to me by my employer. I certify that all statements are true to the best of my knowledge and belief, and I understand that a copy of this form will be made available to me at my request.

Employee Signature: _____ Date: _____

WAIVER

The benefit options shown above has been offered to me. As indicated on this form, I have chosen a waiver of benefits effective April 1, 2024. I understand that I may be subject to evidence of insurability, pre-existing rules and/or waiting periods at the next benefit enrollment period for a benefit option I did not enroll in upon my original eligibility date or that I am not enrolling in at this time.

Employee Signature: _____ Date: _____

HUMAN RESOURCES ONLY

Employee Hire Date: _____ Salary: _____

Date Enrollment Completed _____ Date of Termination of Benefits: _____