## **Benefit Election Form**

**AMCO Transportation Company** 

January 1, 2025 - December 31, 2025

All employees must complete section A, B, and K regardless of waiving or enrolling in benefits

A. Enrollment Type - <i>Check One</i> :		☐ Open Enrollment	☐ Status Change		☐ New Hire		☐ Other			
Date of Hire:	_//_		Qualifying Event	t Type:						
Coverage Effective Date:	_//_		Date of Event: _	//						
B. Personal Information										
LAST NAME		FIRST NAME				Middle Initial				
SOCIAL SECURITY NUMBER		DATE OF BIRTH		GENDER (Circle One )						
		2.0.2 6. 2.0		M / F						
MAILING ADDRESS: (Check b	ov if now addra	<u></u>	CITY		STATE		ZIPCODE	-		
IVIAILING ADDRESS: (Check b	ox ii new addre	SS LL )	Ci	11 1	SIAIE		ZIPCODE			
		T				Γ				
TELEPHONE		EMAIL								
MARITAL STATUS:	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Separated					
C. Employment Information	n									
Job Occupation:		Salary Amount:		Salary Mode:						
			☐ Yearly ☐ Mont	Yearly □ Monthly (12) □ Bi-Weekly (26) □ Semi-Monthly (24)						
				□ Weekly (52) □	] Hourly					
		202	25 BENEFIT E	ELECTIONS						
D. Health Plan	□ Float /	Change Complete Sect	ion Polow	ПМо	Change	□ Waiwa		=		
D. Health Plan	☐ Elect/Change - Complete Section Below ☐ No Change ☐ Waive									
To Elect/Change coverage please	Summary of Employee Costs per pay period  Medical Plan Options									
select: Medical Plan and Coverage Level.	-1									
	Plan Options	Employee Only	Employee + Spouse*		Employee + Child(ren)*		Employee + Family*			
To waive health coverage please check the waive box above.	PPO Plan				□ 6422.20		<b>—</b> 4			
	(S663CHC)	□ \$44.43	□ \$133.29		□ \$133.29		□ \$222.14			
								٦		
	LIMO Diam									
	HMO Plan	□ \$29.11	□ \$ <b></b>	87.33	□ \$8	37.33	□ \$145.55			
	HMO Plan (S644ADT)	□ \$29.11	\$; \$;	87.33	□ \$8	37.33	□ \$145.55 	Ⅎ		
E. Dental Plan	(S644ADT)	□ \$29.11 Change - Complete Sect			□ \$8 Change	37.33	□ \$145.55			
	(S644ADT)	·	ion Below		Change		□ \$145.55			
E. Dental Plan  To Elect/Change coverage please select: Dental Plan and Coverage	(S644ADT)	·	ion Below	□ No of Employee Cost	Change ts per pay period		□ \$145.55			
To Elect/Change coverage please	(S644ADT)	·	ion Below	□ No	Change ts per pay period		□ \$145.55			
To Elect/Change coverage please select: Dental Plan and Coverage Level.	(S644ADT)	Change - Complete Sect	ion Below Summary	□ No of Employee Cost	Change ts per pay period		□ \$145.55  Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage	(S644ADT)  □ Elect/  Plan Options	Change - Complete Sect  Employee Only	ion Below Summary Employee	☐ No  v of Employee Cost  Dental Plate  + Spouse*	Change  ts per pay period  n  Employee +	☐ Waive	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.	(S644ADT)	Change - Complete Sect	ion Below Summary Employee	□ No  of Employee Cost  Dental Plan	Change  ts per pay period  n  Employee +	☐ Waive				
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please	(S644ADT)  □ Elect/  Plan Options	Change - Complete Sect  Employee Only	ion Below Summary Employee	☐ No  v of Employee Cost  Dental Plate  + Spouse*	Change  ts per pay period  n  Employee +	☐ Waive	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents,	(S644ADT)  □ Elect/  Plan Options	Change - Complete Sect  Employee Only	ion Below Summary Employee	☐ No  v of Employee Cost  Dental Plate  + Spouse*	Change  ts per pay period  n  Employee +	☐ Waive	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents,	(S644ADT)  □ Elect/  Plan Options  Dental Plan	Change - Complete Sect  Employee Only	ion Below  Summary  Employee	□ No v of Employee Cost  Dental Plane + Spouse*  14.51	Change  ts per pay period  n  Employee +	☐ Waive	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan	(S644ADT)  □ Elect/  Plan Options  Dental Plan	Change - Complete Sect  Employee Only   \$7.14	ion Below  Summary  Employee	□ No  v of Employee Cost  Dental Plane + Spouse*  14.51 □ No	Change  ts per pay period  Employee +	□ Waive  Child(ren)*	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan  To Elect/Change coverage please	(S644ADT)  □ Elect/  Plan Options  Dental Plan	Change - Complete Sect  Employee Only   \$7.14	ion Below  Summary  Employee	□ No v of Employee Cost  Dental Plane + Spouse*  14.51	Change  ts per pay period  Employee +	□ Waive  Child(ren)*	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan	(S644ADT)  □ Elect/  Plan Options  Dental Plan	Change - Complete Sect  Employee Only   \$7.14	ion Below  Summary  Employee	□ No  v of Employee Cost  Dental Plane + Spouse*  14.51 □ No	Change  ts per pay period  Employee +  Change  Change	□ Waive  Child(ren)*	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan  To Elect/Change coverage please select: Vision Plan and Coverage Level.	Plan Options Dental Plan	Change - Complete Sect  Employee Only  □ \$7.14  Change - Complete Sect	ion Below  Summary  Employee  \$\( \)\$	□ No  v of Employee Cost  Dental Pla  + Spouse*  14.51  □ No  v of Employee Cost  Vision Plar	Change  ts per pay period  Employee +  Change  Change	☐ Waive  Child(ren)*  21.46  ☐ Waive	Employee + Family*  □ \$31.02			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan  To Elect/Change coverage please select: Vision Plan and Coverage Level.  To waive Vision coverage please	(S644ADT)  □ Elect/  Plan Options  Dental Plan	Change - Complete Sect  Employee Only  □ \$7.14  Change - Complete Sect	ion Below  Summary  Employee  \$\( \)\$	□ No v of Employee Cost  Dental Plan e + Spouse*  14.51 □ No v of Employee Cost	Change  ts per pay period  Employee +  Change  Change	□ Waive  Child(ren)*	Employee + Family*			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan  To Elect/Change coverage please select: Vision Plan and Coverage Level.	Plan Options Dental Plan	Change - Complete Sect  Employee Only  □ \$7.14  Change - Complete Sect	ion Below  Summary  Employee    \$2	□ No  v of Employee Cost  Dental Pla  + Spouse*  14.51  □ No  v of Employee Cost  Vision Plar	Change  ts per pay period  Employee +  Change  ts per pay period  Employee +	☐ Waive  Child(ren)*  21.46  ☐ Waive	Employee + Family*  □ \$31.02			
To Elect/Change coverage please select: Dental Plan and Coverage Level.  To waive dental coverage please check the waive box above.  *If you are covering Dependents, please complete Section J.  F. Vision Plan  To Elect/Change coverage please select: Vision Plan and Coverage Level.  To waive Vision coverage please	Plan Options  Dental Plan  Elect/	Change - Complete Sect  Employee Only  \$7.14  Change - Complete Sect  Employee Only	ion Below  Summary  Employee    \$2	□ No  v of Employee Cost  Dental Plane + Spouse*  14.51 □ No  v of Employee Cost  Vision Plane + Spouse*	Change  ts per pay period  Employee +  Change  ts per pay period  Employee +	☐ Waive  Child(ren)*  Waive  Child(ren)*	Employee + Family*  Employee + Family*			

2025 BENEFIT ELECTIONS CONT'D										
		ENEFII ELEC	HONS CONT	ער						
G. Basic Life and AD&D and LTD - Employer Paid										
AMCO provides all full time emp	loyees with a \$20,000 Basic Life and AD&D	policy thorugh G	uardian. Please	designate your be	eneficiary in sec	tion K.				
H. Voluntary Life and AD&D 🗆 Elect/Change -		Complete Section Below		☐ No Change		☐ Waive				
□ Lwich to change /clost \/o	These guarantee									
☐ I wish to change/elect Voluntary Life and AD&D		•Employee:		Up to \$50,000						
Employee: \$			•Spouse:	Up to \$10,000						
Spouse: \$			●Child(ren)	Up to \$10,000						
*Please complete an <b>Evidence of Insurability Form</b> if applying for amounts over the guaranteed issue limits C you previously waived coverage for this plan. Contact Human Resources for this form.										
	1.0	EDENIDENT INC	ODNANTION							
	List all eligible depend	EPENDENT INF		s selected above	•					
Last Name	First Name	Date of Birth  mm/dd/yyyy	GENDER	Social Security Number		Relationship				
		/ /	M/F			Spouse				
		/ /	M/F			Child				
		1 1	M/F			Child				
		/ /	M/F			Child				
		/ /	M/F			Child				
•	the same address as the employee?		Yes	□ No						
If no, list name & address:										
	K.	Beneficiary D	esignation							
	oceeds are pair to primary surviving beneficiaries in equ	ual shares. Proceeds ar	re paid to contingent							
contingent beneficiaries and do not desi	gnate percentages, proceeds are paid to the surviving o divided proportionately among the su	_	•			eficiary who dies before the insured will be				
		PRIMARY BENEFIC	1 ' '		1					
Last Name	First Name	Date of Birth	Relat	ionship	% (total must equal 100%)					
		NITINGENIT BENE	FIGUR DV/IEC)							
CONTINGENT BENEFICIARY(IES)  Last Name First Name Date of Birth Relationship % (total must equal 100%)										
Lust Nume	riistitaine	Date of Birth	Keide	.ionamp	76	/o (cotta: mast equal 2007)				
	L. Insu	rance Deduction	on Agreement	t						
to reflect the change in rates charged spouse or dependent; birth of a depe commencement or return from an ur your dependents either satisfies or co	nation I have received regarding my options und by the carriers. I acknowledge that my election indent; birth or adoption of a child; change in numpaid leave of absence; a change in worksite; or a eases to satisfy requirements for coverage due to above. If necessary, I authorize Sawyer Compositify status changes.	is irrevocable unles mber of dependents any change in emplo o change in age, stud	ss there is a change s; termination of er byment status that dent status, or any	e in my status. A cha mployment or comm affects eligibility; a c similar circumstance	nge in status inclu nencement of emp change in residenc es; or a change in r	des: marriage; divorce; death of a loyment; a strike or lockout; e for you, your spouse or children; or my or my spouse's employment status.				
Employee Name										
(Please Print)					_					
Employee Signature					Date					
Questions? Contact your HUB International Account Manger, Sylvia Uranga, at sylvia.uranga@hubinternational.com or call (817) 529-5314										