☐ **Easy Enroll (not applicable to new enrollees). Check this box if you want to keep everything the same as last year.**

INSTRUCTIONS

Your benefit options are identified in the following sections. Please review your options carefully, then indicate your selections in each section that applies. Once you are finished making your elections, please submit your completed form to the Benefits Department.

EMPLOYEE DETAILS

First Name _____ **Social Security #** _____
Last Name _____ **Date of Birth** _____
Address _____ **Cell/Home Phone** _____
City _____ **Gender** ☐ **Male** ☐ **Female**
State _____ **Zip Code** _____ **Marital Status** ☐ **Single** ☐ **Married**
☐ Check this box if address has changed in last 12 months

Job Title _____

Email Address _____

ENROLLMENT DETAILS

☐ **New Employee** ☐ **Open Enrollment** ☐ **Enrollment Change & Reason** _____
☐ **Address Change** ☐ **Name Change** ☐ **Beneficiary Change**

Effective Date _____
Date of Hire _____
Weekly Hours Worked _____

BENEFIT PLAN SELECTION

Your plan options and per paycheck costs are indicated below.

	Cigna Medical 100% (STL only)	Cigna Medical 90% Plan	Cigna Medical HDHP H.S.A. Compatible	Cigna Dental Plan	Cigna Vision Plan
	Cost Per Pay	Cost Per Pay	Cost Per Pay	Cost Per Pay	Cost Per Pay
Employee Only	☐ $218.00	☐ $132.00	☐ $ 70.00	☐ $12.01	☐ $3.07
Employee + Child(ren)	☐ $414.00	☐ $250.50	☐ $202.00	☐ $26.81	☐ $6.14
Employee + Spouse	☐ $549.50	☐ $369.00	☐ $317.50	☐ $23.92	☐ $5.83
Employee + Family	☐ $653.50	☐ $395.50	☐ $326.00	☐ $38.05	☐ $9.02
	☐ Waive Coverage	☐ Waive Coverage	☐ Waive Coverage	☐ Waive Coverage	☐ Waive Coverage

FAMILY DETAILS (list dependents to be insured)

A=Add R=Remove		Name (Last, First)	Social Security No.	Date of Birth	Gender
	Spouse				
	Child				
	Child				
	Child				
	Child				
	Child				

HSA ELECTION (Only available with the HDHP Medical Plan)

Health Savings Account/HSA CONTRIBUTIONS – The IRS limits HSA contributions on a tax/calendar year basis. The tax/calendar year limits are shown below and represent the total allowed including employer contributions if applicable:

2025 Max: Individual: **$4,300**
2025 Max: Family: **$8,550**

2026 Max: Individual: **$4,400**
2026 Max: Family: **$8,750**

Michelson is offering a 100% matching contribution up to the following amounts per paycheck:
$23.08 for Single Coverage (up to $600/year)
$53.08 for Single/Child Coverage (up to $1,380/year)
$60.00 for Couple Coverage (up to $1,560/year)
$69.24 for Family Coverage (up to $1,800/year)

How much would you like to contribute to your HSA per pay period? $ _____

FSA ELECTION

Dependent Care Flexible Spending Account/DCFSA ELECTION (BASED ON CALENDAR YEAR 01/01– 12/31):

Annual Salary Reduction Election

☐ **Dependent Care Expenses: $_____($5,000 max)** ☐ **Waive**

VOLUNTARY LONG TERM DISABILITY BENEFIT

(If you previously waived this benefit, you will need to complete a medical questionnaire.)

LONG TERM DISABILITY ELECTION

Long Term Disability will pay out up to half of your annual salary. Cost depends on the monthly benefit pay out you choose and the age bracket you are in. You must make at least the minimum annual salary amount in order to choose that benefit. Otherwise, you will be automatically be moved to the correct benefit level upon enrollment.

		Election Cost Per Age Bracket							
Monthly Benefit	*Minimum Annual Salary*	*<30*	*30-34*	*35-39*	*40-44*	*45-49*	*50-54*	*55-59*	*60+*
$500	$12,000	$0.95	$1.85	$2.35	$2.95	$4.40	$7.40	$9.85	$10.25
$750	$18,000	$1.43	$2.78	$3.53	$4.43	$6.60	$11.10	$14.78	$15.38
$1,000	$24,000	$1.90	$3.70	$4.70	$5.90	$8.80	$14.80	$19.70	$20.50
$1,250	$30,000	$2.63	$5.13	$6.50	$8.13	$12.25	$20.50	$27.38	$28.50
$1,500	$36,000	$3.45	$6.90	$8.55	$10.50	$15.90	$26.85	$35.40	$37.05
$2,000	$48,000	$5.20	$11.00	$14.20	$17.00	$25.60	$42.80	$57.00	$59.60
$2,500	$60,000	$7.50	$14.75	$18.75	$22.75	$34.75	$58.00	$77.50	$81.25

☐ **Yes, enroll in Long Term Disability** ☐ **Waive** **Monthly Benefit Amount:** _____

ADDITIONAL EMPLOYEE PAID VOLUNTARY GROUP TERM LIFE INSURANCE

To elect or change Voluntary Group Term Life insurance, please indicate the coverage amount in the applicable space below. You (the employee) must elect coverage for yourself in order to purchase coverage for your spouse and/or dependent child(ren).

Employee Units of $10,000 up to $300,000 Guaranteed Coverage: $150,000		**Spouse** Units of $5,000 up to $50,000 Guaranteed Coverage: $10,000 **(Cannot exceed 50% of the employee's election)**		**Child(ren)** Units of $1,000 up to $10,000	
Coverage Amount	**Cost Per Pay**	**Coverage Amount**	**Cost Per Pay**	**Coverage Amount**	**Cost Per Pay**
☐ $ _____	$ _____	☐ $ _____	$ _____	☐ $ _____	$ _____
☐ **Waive Coverage**		☐ **Waive Coverage**		☐ **Waive Coverage**	

Employee's Monthly Cost of Coverage:

Age	Employee Cost Per $10,000 Unit	Spouse Cost Per $5,000 Unit	Age	Employee Cost Per $10,000 Unit	Spouse Cost Per $5,000 Unit
0-19	$0.600	$0.300	60-64	$12.000	$6.000
20-24	$0.600	$0.300	65-69	$19.700	$9.850
25-29	$0.600	$0.300	70-74	$28.900	$14.450
30-34	$0.800	$0.400	75-79	$52.800	$26.400
35-39	$0.900	$0.450	80-84	$80.700	$40.350
40-44	$1.400	$0.700	85-89	$147.700	$73.850
45-49	$2.200	$1.100	90-94	$199.300	$99.650
50-54	$3.700	$1.850	95-99	$434.700	$217.350
55-59	$6.600	$3.300			

Child Cost Per $1,000 Unit = $0.150

Actual per pay period premiums may differ slightly due to rounding. All spouse rates are based upon employee age. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Monthly Cost:

Step 1: Use the chart above to find your **Monthly** rate based on your age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.
Step 3: The result is the **Monthly** cost.

EMPLOYER PAID	Guardian Basic Life/AD&D $10,000
	Cost Per Pay
Employee Only	☒ $0

LIFE AND AD&D INSURANCE BENEFICIARY DESIGNATION

All eligible employees must make their beneficiary designation in the space provided below for their Life and AD&D insurance benefits. A beneficiary is required to satisfy the requirements of the company provided life insurance and must be provided regardless of election of voluntary coverage. In the absence of a designation on this form, your Basic Life and AD&D Insurance benefits will be paid to your estate (if one has been established).

Employee's Primary Beneficiary	**Employee's Contingent Beneficiary**
Name____________________	**Name**____________________
Social Security No.________________	**Social Security No.** ________________
Date of Birth__________________	**Date of Birth**__________________
Relation to Insured_______________	**Relation to Insured**_______________
***Percentage of Benefit**_____________	***Percentage of Benefit**_____________
Employee's Primary Beneficiary	**Employee's Contingent Beneficiary**
Name____________________	**Name**____________________
Social Security No.________________	**Social Security No.** ________________
Date of Birth__________________	**Date of Birth**__________________
Relation to Insured_______________	**Relation to Insured**_______________
***Percentage of Benefit**_____________	***Percentage of Benefit**_____________
Employee's Primary Beneficiary	**Employee's Contingent Beneficiary**
Name____________________	**Name**____________________
Social Security No.________________	**Social Security No.** ________________
Date of Birth__________________	**Date of Birth**__________________
Relation to Insured_______________	**Relation to Insured**_______________
***Percentage of Benefit**_____________	***Percentage of Benefit**_____________
Employee's Primary Beneficiary	**Employee's Contingent Beneficiary**
Name____________________	**Name**____________________
Social Security No.________________	**Social Security No.** ________________
Date of Birth__________________	**Date of Birth**__________________
Relation to Insured_______________	**Relation to Insured**_______________
*** Percentage of Benefit**_____________	***Percentage of Benefit**_____________
**Percent of Benefit must total 100%*	**Percent of Benefit must total 100%*

AUTHORIZATION

I request insurance under the group coverage(s) issued to my employer. I understand and have verified the benefit selections I have made and hereby authorize any payroll deductions required to keep my insurance in force. I also understand that benefit deductions may be adjusted throughout the plan year based on date of hire and reconciliations performed. I understand that the selections for medical, dental and vision (which are pre-tax payroll deductions) will be in effect for the plan year and may not be changed during the year unless I have a qualified life event as defined by the IRS. I understand that any request for such change must be made in writing to my employer within 30 days of the qualifying event.

I certify (1) I am employed by *Michelson Realty Company LLC or Michelson Commercial Realty and Development L.L.C.* and at present am working at least 30 hours per week; (2) the information shown is correct to the best of my knowledge; (3) I understand any incorrect statements may result in my coverage or my dependents coverage being terminated, rescinded, and/or claims not paid; (4) I have read this form; (5) I authorize the insurance carrier(s) to verify all my information.

I agree Michelson Realty Company acts as my agent in all dealing with the Plan(s) and has my consent to share necessary information with Insurance Companies or their representatives as needed. I agree all notices given by my employer are binding upon me. I also agree my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

______________________________ ______________________________

Signature Date