VITAL HEALTH AMERICA

BENEFITS ENROLLMENT FORM

JANUARY 1, 2026 THROUGH DECEMBER 31, 2026

1. EMPLOYEE INFORMATION

Name (please print):		Social Security #:
Address:	Date of Birth (MM/DD/YYYY):	Date of Hire:
City:	State:	ZIP:
Phone Number:	Email Address:	
Event: ☐ New Hire ☐ Qualifying Life Event (QLE) Date of Hire or QLE: _____	Gender:	Marital Status:

2. MEDICAL PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

Bi-Weekly Salary		OAMC HDHP WITH HSA	EPO
Less than $1,000	**Employee Only**	☐ $61.00	☐ $84.00
	Employee + Child(ren)	☐ $89.00	☐ $124.00
	Employee + Spouse	☐ $116.00	☐ $162.00
	Employee + Family	☐ $157.00	☐ $219.00
$1,000 – $2,000	**Employee Only**	☐ $81.00	☐ $134.00
	Employee + Child(ren)	☐ $119.00	☐ $197.00
	Employee + Spouse	☐ $155.00	☐ $257.00
	Employee + Family	☐ $210.00	☐ $348.00
$2,000 – $4,000	**Employee Only**	☐ $102.00	☐ $184.00
	Employee + Child(ren)	☐ $149.00	☐ $270.00
	Employee + Spouse	☐ $194.00	☐ $353.00
	Employee + Family	☐ $262.00	☐ $477.00
$4,000 – $8,000	**Employee Only**	☐ $122.00	☐ $233.00
	Employee + Child(ren)	☐ $178.00	☐ $344.00
	Employee + Spouse	☐ $233.00	☐ $448.00
	Employee + Family	☐ $315.00	☐ $605.00
$8,000+	**Employee Only**	☐ $183.00	☐ $273.00
	Employee + Child(ren)	☐ $268.00	☐ $402.00
	Employee + Spouse	☐ $349.00	☐ $524.00
	Employee + Family	☐ $472.00	☐ $708.00

☐ **WAIVE MEDICAL COVERAGE**

3. HEALTH SAVINGS ACCOUNT – INSPIRA

Please check (✓) one box

If you elect to participate in the Aetna OAMC HDHP Plan, you may contribute funds to an HSA on a pre-tax basis. The annual HSA contribution maximums are **$4,400 for Employee Only Coverage** and **$8,750 for all other coverage levels**. If you are age 55 or older, you may contribute an additional **$1,000** (regardless of the coverage level you elected).

If you are interested in participating in an HSA, please check the box below and list your annual and per-pay contribution amounts.

☐ **YES**, I would like to participate in the Health Savings Account through Inspira

My **ANNUAL** Contribution: $_____ My **PER-PAY** Contribution: $_____

4. DENTAL PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	DPPO	DHMO
Employee Only	☐ $18.78	☐ $5.04
Employee + Child(ren)	☐ $39.20	☐ $17.62
Employee + Spouse	☐ $39.03	☐ $17.62
Family	☐ $63.13	☐ $17.62

☐ **WAIVE DENTAL COVERAGE**

5. VISION PLAN SELECTION (BI-WEEKLY CONTRIBUTIONS)

	Aetna Vision Plan
Employee Only	☐ $3.93
Employee + Children	☐ $7.86
Employee + Spouse	☐ $7.47
Family	☐ $11.56

☐ **WAIVE VISION COVERAGE**

6. DEPENDENT ENROLLMENT INFORMATION (ALL FIELDS REQUIRED)

Dependent First & Last Name	Gender (M/F)	Relationship (Spouse, DP, Child)	Date of Birth (MM/DD/YYYY)	Social Security #	Add/Cancel Coverage	Select Plan(s) to Add/Cancel
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision
					☐ Add ☐ Cancel	☐ Medical ☐ Dental ☐ Vision

7. BASIC LIFE/ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AND LONG-TERM DISABILITY (LTD)

Vital Health offers our employees Basic Life and AD&D Insurance and Long-Term Disability Insurance. **Vital Health pays 100% of the premium for both of these benefits and enrollment is automatic.**

Please indicate your beneficiary designation for your Life Insurance benefits in the event of your death. You may indicate a Primary and Contingent Beneficiary. You may also name more than one Primary and/or Contingent Beneficiary. Unless designated otherwise, payment will be made in equal shares or all to the survivor. You have the right to change this beneficiary designation at any time.

Beneficiary Type	Beneficiary Name	Beneficiary Address	Date of Birth	SSN	Relationship	% of Benefit
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						
☐ P ☐ C						

8. EMPLOYEE VOLUNTARY LIFE AND AD&D—LINCOLN FINANCIAL

Employee Election:

- Minimum election: **$10,000**
- Maximum election: **$500,000**
- Guaranteed issue: **$300,000**

☐ Elect coverage amount: $_____

You will be REQUIRED to complete the Evidence of Insurability (EOI) form if you elect more than the Guarantee Issue amount for yourself if you are electing coverage after your initial eligibility period. Completion of this form does not guarantee the Voluntary Life amount

Spouse Election:

- Minimum election: **$5,000**
- Maximum election: **$250,000**
- Guaranteed issue: **$30,000**

☐ Elect coverage amount:

Child(ren) Election:

- Minimum election: **$1,000**
- Maximum election: **$10,000**
- Guaranteed issue: **$10,000**

☐ Elect coverage amount:

REQUIRED to complete the Evidence of Insurability (EOI) form if you elect more than the Guarantee Issue amount for yourself if you are electing coverage after your initial eligibility period. Completion of this form does not guarantee the Voluntary Life amount requested will be

9. VOLUNTARY SHORT-TERM DISABILITY—LINCOLN FINANCIAL

Please check (✓) one box

☐ **Elect** STD Coverage

☐ **Waive** STD Coverage

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the Plan Year, unless there is a change in family status, under the terms of the Plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through Vital Health during the open enrollment period each year and during the year within 30 days of a qualified change in status.

*By enrolling in medical, dental and vision I am authorizing Vital Health take the necessary contributions from my salary for the benefits in which I have enrolled on a **BEFORE-TAX** basis. I understand benefits choices will be irrevocable (with the exception of the transit account) 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**. Prior to December 31 of each year, I will be offered the opportunity to elect coverage for the following Plan Year. If I do not complete and return a new Benefit Election Form at that time, I will be treated as having elected to continue all before tax benefits under the Plan for the following Plan Year.*

Employee Signature: _____ **Date:** _____