THE PILOTS ASSOCIATION FOR THE BAY AND RIVER DELAWARE
2025 EMPLOYEE ENROLLMENT/WAIVER FORM

Complete Enrollment Form with your 2025 plan elections. Please sign the authorize elections OR the waiver of Coverage section.

EMPLOYEE INFORMATION	
NAME: FIRST MIDDLE LAST	SOCIAL SECURITY NO.
STREET ADDRESS	CITY
STATE	ZIP CODE
SALARY	DATE OF BIRTH
POSITION TITLE	DATE OF HIRE
EMAIL ADDRESS	

MEDICAL- For annual salaries under $50,000, excluding overtime	
Medical Plan Options (check only one)	Medical Level of Coverage (check only one)
☐ *Independence Blue Cross HSA $3000/$30-$60/$500	☐ Employee Only - $157.69 / Monthly ☐ EE + Spouse - $362.83 / Monthly ☐ EE + Child/ren - $281.16 / Monthly ☐ Family - $462.65 / Monthly
☐ I elect to Waive Medical Coverage	

MEDICAL – For annual salaries between $50,000 and $99,999, excluding overtime	
Medical Plan Options (check only one)	Medical Level of Coverage (check only one)
☐ * Independence Blue Cross HSA $3000/$30-$60/$500	☐ Employee Only - $176.60 / Monthly ☐ EE + Spouse - $406.38 / Monthly ☐ EE + Child/ren - $314.89 / Monthly ☐ Family - $518.17 / Monthly
☐ I elect to Waive Medical Coverage	

MEDICAL – For annual salaries over $100,000	
Medical Plan Options (check only one)	Medical Level of Coverage (check only one)
☐ * Independence Blue Cross HSA $3000/$30-$60/$500	☐ Employee Only - $189.22 / Monthly ☐ EE + Spouse - $435.40 / Monthly ☐ EE + Child/ren - $337.38/ Monthly ☐ Family - $555.17 / Monthly
☐ I elect to Waive Medical Coverage	

*** Enrolling in this plan automatically entitles you to the Health Reimbursement Account (HRA)**

Dental	
☐ Unum – PPO Dental	☐ Employee Only - $8.92 / Monthly ☐ EE + Spouse - $23.54 / Monthly ☐ EE + Child/ren - $23.54 / Monthly ☐ Family - $23.54 / Monthly
☐ I elect to Waive Dental Coverage	
VISION	
☐ EyeMed – Vision	☐ Employee Only - $7.64 / Monthly ☐ EE + Spouse - $14.52 / Monthly ☐ EE + Child/ren - $15.28 / Monthly ☐ Family - $22.46 / Monthly
☐ I elect to Waive Vision Coverage	

ALLSTATE IDENTITY PROTECTION PRO+	
Identity Protection	
☐ Allstate Identity Protection	☐ Employee Only - $9.95 / Monthly ☐ Family - $17.95 / Monthly
☐ I elect to Waive Identity Protection Coverage	

EMPLOYEE and DEPENDENT INFORMATION FOR MEDICAL, DENTAL AND VISION							
Name of each Dependent to be covered	Relation to employee (self, spouse, child)	Sex (M/F)	Date of Birth	Social Security	Covered for Medical (Y/N)	Covered for Dental (Y/N)	Covered for Vision (Y/N)
Employee:							
1							
2							
3							
4							
5							

If additional dependents, please add another sheet

AUTHORIZE ELECTIONS

☐ By checking the box and signing below, I acknowledge that I understand the terms and conditions of the benefit(s) and any payments to which I have agreed. I give my express consent authorizing the company to take deductions from my paycheck to pay for the costs of the benefit(s) listed above. I acknowledge that these deductions are for my benefit.

☐ By checking the box and signing below, I hereby acknowledge that this election is irrevocable; in other words, I cannot change my election, whether to increase, add, decrease or remove benefits, except at open enrollment or in case of certain qualifying life events.

☐ By checking the box and signing below, I hereby authorize the Benefits Department to send necessary personal information to my selected insurance carriers to initiate and support coverage.

EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

WAIVER OF COVERAGE

Having met the eligibility requirements, you are being offered the opportunity to enroll in health coverage offered by The Pilots' Association for the Bay and River Delaware. You have the right to decline, or waive coverage. If you do waive coverage for yourself, you may not cover dependents under the Employer's health plan.

Note that if you waive coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

The decision to waive coverage has consequences for you. For example:

- If you waive coverage, you cannot enroll in The Pilots' Association for the Bay and River Delaware's health plan until the next open enrollment, unless you experience a qualified change in status. Examples include if you are covered under another plan, but that coverage is lost, or if you gain a new dependent through birth, adoption, or marriage. However, you must request to enroll in your plan within 30 days of the qualified change in status. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the period from 1/1/2025 to 12/31/2025. I have read the above and I understand the consequences of my waiver of coverage.

_____

Name of Employee

_____ _____

Signature of Employee Date

As a representative of the Employer, I received this Waiver of Coverage from the above employee on

_____ (Date).

_____

Signature of the Employer Representative

BENEFICIARY DESIGNATION FORM
GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT
CRITICAL ILLNESS AND ACCIDENT INSURANCE
Unum Life Insurance Company of America
Unum Insurance Company
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI) | Social Security Number

Policy Number(s) | Division Number(s)

Employer Name | Check the coverages listed below to which this beneficiary designation applies:
☐ Basic Life ☐ Critical Illness ☐ Accident
☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

1. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)
2. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)
3. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)

BENEFICIARY DESIGNATION FORM
GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT
CRITICAL ILLNESS AND ACCIDENT INSURANCE

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

1. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)
2. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)
3. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act,which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SECTION 4: Signature

The above statements are true and complete to the best of my knowledge and belief.

X _____ _____
Employee Signature **Date**

Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust** – You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.

- **Supplemental Life** is life insurance elected by you for which you pay the premiums.

- **AD&D** is Accidental Death & Dismemberment coverage.

- **Critical Illness** is insurance elected by you for which you pay the premium.

- **Accident** is insurance elected by you for which you pay the premiums.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.