

## Foremost/Stockmeister Group 2024 Enrollment Form

Name (First, N	/II, Last)		Employee S	SN	Company	Company	
Home/Mailing	g Address (please include street,	city, state, zip)	Employee D	ate of Birth	Date of Hire	Date of Hire	
Contact Info: F	Phone/Email				1		
This is a:	■ NEW ENROLLMENT	☐ CHANGE of ENROLL	MENT		OPEN ENROLLMENT/REE	NROLLMENT	
		t you wish to cover under one or mo				al.	
Relationship Code**	Name (First, MI, Last)	Social Security Number	Date of Birth	Gender M or F	Coverage Elections	Change	
		1000000		III GI I	Medical Dental Vision Voluntary Life	☐ Add	
					☐ Medical ☐ Dental☐ Vision☐ Voluntary Life	☐ Add	
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					☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life	☐ Add	
·	Code: SP=Spouse CH=Child CO=Co	2024-2025 Plan Ele	ctions	,			
	an election in EACH covera Plan Selection	ge below: Tier Election					

## Medical □ Employee Only Employee + Child(ren) ☐ Enroll – Anthem/MMP Gap Employee + Spouse **Employee + Family** ☐ Include MetLife BASIC LIFE (\$20,000) Decline/Waive **Employee Only** Employee + Child(ren) Voluntary Dental – MetLife Employee + Spouse Employee + Family ☐ Enroll Dental Decline/Waive Employee + Child(ren) Voluntary Vision - MetLife **Employee Only** Employee + Spouse Employee + Family ■ Enroll Vision Decline/Waive Voluntary Life - Employee New Amount: \$ □ Cancel □ Add □ Increase $\Box$ Add □ Increase New Amount: \$ □ Cancel Voluntary Life - Spouse Add □ Increase New Amount: \$ □ Cancel Voluntary Life - Child(ren)

Contingent Beneficiary Name Address Date of Birth Relationship Benefit  Waiver/Declination of Coverage: Complete this Section ONLY if you are NOT enrolling for any coverage(s):  Reason for decline/waiver of coverage:  I understand that by waiving coverage at this time, I will NOT	Beneficiary – Employees <u>MUS</u>	<u>Complete for Employer Pr</u>	ovided Bas	ic Life/Al	D&D and Volunta	ry Life Coverage:			
Waiver/Declination of Coverage: Complete this Section ONLY if you are NOT enrolling for any coverage(s):   Reason for decline/waiver of coverage:   Spouse's Employer Plan	Primary Beneficiary Name	Address			Date of Birth	Relationship	Benefit %		
Waiver/Declination of Coverage: Complete this Section ONLY if you are NOT enrolling for any coverage(s):   Reason for decline/waiver of coverage:									
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Reason for decline/waiver of coverage:    Spouse's Employer Plan	Contingent Beneficiary Name	e Address			Date of Birth	Relationship	Benefit %		
Reason for decline/waiver of coverage:    Spouse's Employer Plan									
Reason for decline/waiver of coverage:    Spouse's Employer Plan									
Reason for decline/waiver of coverage:    Spouse's Employer Plan									
Reason for decline/waiver of coverage:    Spouse's Employer Plan									
Reason for decline/waiver of coverage:  Spouse's Employer Plan Other* Covered by Medicare/Medicaid *State Reason: Interest and that by walving coverages at this time, I will NOT enrolled in any of the offered coverages. I understand that I was not be allowed to participate unless I experience a qualified event, enroll during the next Open Enrollment period or as late enrollee, if applicable.    Pre-Tax Premium Elections									
Reason for decline/waiver of coverage:  □ pouse's Employer Plan □ Covered by Medicare/Medicaid □ State Reason: □ Dither*  "State Reason: □ State Reason: □ Covered by Medicare/Medicaid □ State Reason: □ Stat	Waiver/Declination of Cov	erage: Complete this Sec	ction ONL	Y if you a	are NOT enrollir	ng for any coverag	ge(s):		
spouse's Employer Plan Covered by Medicare/Medicaid  *State Reason:  Employee Signature Required for Waiver:  Section 125 Cafeteria Premium Dnly Plan Section  Pre-Tax Premium Elections Coverage Per Paycheck Premium Medical S Dental  S Total to withheld pre-tax each paycheck  Province A graph of the Benefit Plan for which I am or may become eligible under the plan created by the above Plan Sponsor; (2) at I will abide by the provisions set forth in the Summary Plan Description and Plan Document; (3) designate the beneficiary named by releve the benefits, if any, payable in the event of my death and (4) certify the above information to be true and correct to the best coverage delta that I may not revoke or change my participation in this plan until the next plan anniversary unless I experience a change mily status or a change in my or my spouse's employment status. I also authorize the payroll reductions provided by me is true and complete test of my knowledge. I understand that any person who knowledgy and with intent to defraud any insurance company or other person, file months and the provision contained hereir event or my knowledge. I understand that any person who knowledgy and with intent to defraud any insurance company or other person, file months and the stream of the provision contained hereir event to void this contract.				<del></del>		· ·			
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Section 125 Cafeteria Premium Only Plan Section     Pre-Tax Premium Elections		*State Reason:							
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