H U N E E U S

WINES OF THE HUNEEUS FAMILY

HEALTHCARE BENEFIT ELECTION FORM

Plan Year: August 1, 2020- July 31, 2021

EMPLOYEE PERSONAL INFORMATION: All employees *MUST* complete

First Name	**Last Name**	**Brand & Department**
Phone Number	**Date of Birth (DOB)**	**Social Security Number (SSN)**
Street Address	**City**	**State & Zip Code**

DEPENDENT INFORMATION: Complete if enrolling dependents in Medical (M), Dental (D), Vision (V) or All

First Name	Last Name	Relationship	Date of Birth	Social Security Number (SSN)	Please list benefit election (M, D, V or All)

LIFE INSURANCE - DESIGNATION OF BENEFICIARY: All employees *MUST* complete

Primary					
Last Name	**First Name**	**Relationship**	**Date of Birth**	**SSN**	**Benefit Percentage**
Secondary					
Last Name	**First Name**	**Relationship**	**Date of Birth**	**SSN**	**Benefit Percentage**

BENEFIT ELECTION: To enroll, choose plan name & coverage level; benefits are separate. To decline, do not complete.

Plan Name	Employee Only	Employee + Spouse/Domestic Partner	Employee + Child(ren)	Employee + Family
Medical – UnitedHealthcare HRA	☐	☐	☐	☐
Medical – Kaiser HRA	☐	☐	☐	☐
Dental – Anthem Blue Cross PPO	☐	☐	☐	☐
Vision – Anthem Blue Cross Vision	☐	☐	☐	☐

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ENROLLMENT ACKNOWLEDGEMENT & SALARY REDUCTION AGREEMENT

- I authorize Huneeus to deduct from my bi-weekly payroll check on a pre-tax basis for the period of August 1, 2020 through July 31, 2021 for my portion of the cost of medical, dental and vision benefits elected for myself and if applicable, my eligible dependents.
- I acknowledge that my election is irrevocable unless there has been a qualifying change in my family, employment or group health care coverage or during the annual open enrollment period.
- **I understand that if I experience a qualifying change in status, I have thirty (30) days from the date of the event to make a change to my benefits.**
- I understand that my share of the premium may be adjusted to reflect any change in family status and/or rates.
- I understand that I'm responsible for paying my benefits costs shown above during an approved leave of absence in order to continue my coverage.
- In the event my employment is terminated, I authorize Huneeus to deduct any remaining unpaid medical premiums from my final paycheck.

Signature: _____ _____

Print Name: _____ Date: _____ _____

DECLINATION OF BENEFITS

If you are **DECLINING** medical, dental and vision coverage for yourself and/or eligible dependents:

Plan Name	Waiving Coverage	Reason for Waiving Coverage
Medical	☐	
Dental	☐	
Vision	☐	

I acknowledge that the available coverage options have been explained to me by my Employer and I know that I have the right to enroll in the coverage. I have been given the chance to enroll in this coverage, however I have elected not to enroll myself and/or my dependents. BY DECLINING THIS GROUP COVERAGE I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO 12 MONTHS TO BE ENROLLED IN THE HUNEEUS VINTNERS INSURANCE PLANS.

Signature **if declining coverage** for self/dependents: _____

Print Name: _____ Date:_____