COMPASS
FAMILY SERVICES

Employee Name (please print): _____

Compass Open Enrollment Election Form

If you are waiving any, or all, of the benefit plans, please complete/sign the **Waiver of Participation** on page two.

I acknowledge and agree to accept the following conditions relating to the Compass Benefit Program:

1. Compass' Insurance Benefit Plan Year runs from January 1, 2024 to December 31, 2024.

2. ***I understand that my election(s) applies to the entire Plan Year and may not be changed*** unless I have a qualified change of status as defined by the IRS Section 125. Common examples of qualifying events include, but are not limited to marriage, divorce, birth of a child, loss or gain of coverage.

3. All documents relating to the Compass Family Services Benefit Program, including the Summary Plan Descriptions, HIPAA Privacy Notice, Initial COBRA Notice, Medicare Part D Creditable Coverage Notice and any other relevant Plan Documents or Notices, are available to me and my dependents electronically through the broker website at **https://mybenefits.cc/compass/** in the Required Postings section. I also understand that I may receive a paper copy of any of the above documents free of charge by contacting Human Resources.

❑ Check this box if you currently have coverage for only yourself, and/or your spouse, and/or your dependent children, **AND DO NOT WANT TO MAKE CHANGES.** Be sure you have read the above acknowledgments and feel free to reach out to Human Resources if you have any questions.

**** IF YOU ARE NOT MAKING ANY CHANGES STOP HERE ****
**** NO FURTHER ACTION OR SIGNATURE IS REQUIRED ****

❑ Check this box if you would like to add/delete spouse, or dependent children coverage. Choose level of coverage by checking the applicable box(es) below. Read acknowledgements and sign below. In addition to signing below, you will also need to complete the appropriate carrier change form(s), which are available from Human Resources.

PLAN CHOICES	Employee Only	Employee + Spouse / DP	Employee + Child(ren)	Family
❒ Kaiser Medical	❒ $0.00	❒ $750.95	❒ $0.00	❒ $625.78
❒ Direct Dental	❒ $0.00	❒ $ 38.11	❒ $0.00	❒ $ 36.06
❒ Superior Vision	❒ $0.00	❒ $ 5.54	❒ $0.00	❒ $ 6.94
❒ Kaiser, Dental & Vision	❒ $0.00	❒ $794.60	❒ $0.00	❒ $668.78

❑ By checking this box, I acknowledge that I understand that Compass will deduct the amounts reflected below from my wages for the benefits I have elected above during each pay period of this Plan Year. **NOTE:** The amounts listed above are monthly amounts. I understand that the deductions will be made on a pre-tax basis and that such deductions reduce my compensation for Social Security Benefit purposes.

Employee Signature _____ **Date:** _____

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WAIVER OF PARTICIPATION

(*Complete only if you are waiving coverage*)

The Compass Employee Benefits Program has been explained to me and I decline to participate at this time. I understand that as of January 1, 2014, I am required by law to maintain an acceptable level of health insurance coverage for my dependents and myself. I understand that if I waive coverage now, I must wait until the next Plan Year to enroll unless there is a change in my status as defined by Section 125.

I choose **NOT** to enroll in the following plans offered by Compass:

- ❑ MEDICAL
- ❑ DENTAL
- ❑ VISION

Employee Signature: _____ **Date:** _____

Employee Name (Please Print)_____