Serena & Lily Monthly Employee Cost Eff. 01.01.2025

Employee Name: _____

SSN: _____

SERENA & LILY

ELECTION TO PARTICIPATE

I hereby elect to participate in the Serena & Lily Employee Benefits Program. I wish to receive the benefits designated by checkmarks in the boxes below and authorize Serena & Lily to deduct the corresponding amounts from my wages.

THIS FORM MUST BE SUBMITTED WITH THE COINCIDING BENEFIT FORM YOU ARE ELECTING

UnitedHealthcare Select Plan PPO

	Employee Only		EE + Spouse/DP		EE + Child(ren)/DP Child(ren)		EE + Family
❒	$112.26	❒	$523.88	❒	$449.05	❒	$860.67

Guardian PPO Dental

	Employee Only		EE + Spouse/DP		EE + Child(ren)/DP Child(ren)		EE + Family
❒	$0.00	❒	$19.76	❒	$26.43	❒	$57.52

Vision Plan (VSP) through Guardian

	Employee Only		EE + Spouse/DP		EE + Child(ren)/DP Child(ren)		EE + Family
❒	$0.00	❒	$2.72	❒	$2.83	❒	$6.27

VOLUNTARY LIFE and AD&D INSURANCE **Rate per $1,000 of Life Insurance**

Age	Employee & Spouse/DP	All Children
< 25	$0.075	$0.17
25 - 29	$0.075	
30 - 34	$0.075	
35 - 39	$0.115	
40 - 44	$0.165	
45 - 49	$0.235	
50 - 54	$0.405	
55 - 59	$0.615	
60 - 64	$0.635	
65 - 69	$1.155	
70 - 74	$2.425	
75 - 79	$7.235	
80 - 99	$15.595	

To calculate your cost per paycheck, please multiply monthly cost by 12 and divide by 26

I acknowledge and agree to accept the following conditions relating to the Serena & Lily Benefit Program:

1. Serena & Lily's Insurance Benefit Plan Year runs from January 1, 2025 to December 31, 2025.
2. I understand that the above election applies to the entire Plan Year and may not be changed unless I have a qualified change of status as defined by my Serena & Lily's plan (marriage, birth of a child, etc.).
3. I understand that Serena & Lily will deduct the amounts reflected above from my wages for the benefits I have elected, to be calculated on a bi-weekly pay period, of this Plan Year.
4. 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. **NOTE**: The value of health care coverage provided for a domestic partner or any enrolled dependent children of your domestic partner is generally treated as income to you for federal tax purposes (and in most cases, state tax purposes).
5. I understand that all documents relating to the Serena & Lily Employee Benefits Program, including the Summary Plan Descriptions, Summary of Benefits and Coverage, HIPAA Privacy Notice, and any other relevant Plan Documents or Notices, are available to me and my dependents electronically through Serena & Lily's Intranet or through the broker web site at **mybenefits.cc/serenaandlily**. I also understand that I may receive a paper copy of any of the above documents free of charge by contacting my Human Resource department at (415) 939-4411.

Employee Signature: _____ **Date:**_____

WAIVE

The Serena & Lily 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 myself and my dependents. 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 Serena & Lily's plan.

Employee Signature: _____ **Date:**_____