SIFFRIN, INC EMPLOYEE BENEFIT ELECTION FORM EFF 6/1/2023

Employee Name
Social Security #

Date of Birth

Based on 24 Pays

PLAN	Type of Coverage	Siffrin Portion (Month)	Staff Portion (Month)	Staff Portion (Per Pay)	Please Mark One
Sidecar $5,000 Deductible	Employee Only	$ 606.27	$ 142.27	$ 71.14	
	Employee & Spouse	$ 1,151.70	$ 493.59	$ 246.80	
	Employee & Children	$ 884.48	$ 379.06	$ 189.53	
	Family	$ 1,617.53	$ 693.23	$ 346.62	
	Waive Coverage	$ -	$ -	$ -	
Sidecar $2,000 Deductible	Employee Only	$ 606.27	$ 309.15	$ 154.58	
	Employee & Spouse	$ 1,151.70	$ 860.40	$ 430.20	
	Employee & Children	$ 884.48	$ 660.76	$ 330.38	
	Family	$ 1,617.52	$ 1,208.40	$ 604.20	
	Waive Coverage	$ -	$ -	$ -	
Humana Dental (Low Plan)	Employee Only	$ -	$ 17.61	$ 8.81	
$50 Ded; 100/80/50% to $1,000 Max	Employee & Spouse	$ -	$ 35.22	$ 17.61	
Out of Network Claims paid as In-Network	Employee & Children	$ -	$ 44.90	$ 22.45	
	Family	$ -	$ 62.51	$ 31.26	
	Waive Coverage	$ -	$ -	$ -	
Humana Dental (High Plan)	Employee Only	$ -	$ 19.58	$ 9.79	
$50 Ded; 100/100/60% to $1,000 Max	Employee & Spouse	$ -	$ 39.17	$ 19.59	
Out of Network Claims paid as In-Network	Employee & Children	$ -	$ 49.93	$ 24.97	
	Family	$ -	$ 69.51	$ 34.76	
	Waive Coverage	$ -	$ -	$ -	
Humana Vision	Employee Only	$ -	$ 5.99	$ 3.00	
$10/Copay for Routine Eye Exam	Employee & Spouse	$ -	$ 11.99	$ 6.00	
$25/copay for Lenses every year	Employee & Children	$ -	$ 11.39	$ 5.70	
$100 Max on Frames every 2 years	Family	$ -	$ 17.91	$ 8.96	
	Waive Coverage	$ -	$ -	$ -	

By signing below, I understand that the above payroll deductions will be deducted from my pay beginning with first payroll in June 2023. These rates will be guaranteed for 1 year unless I make a coverage change throughout the year.

_____ _____

Signature Date

Updated: 5/1/2023