Wilkins Research Services, Inc.
Employee Election Form / Open Enrollment November 1, 2020

Medical – BlueCross BlueShield of TN (BCBST)

Coverage Type	Option 1 Bi Weekly Deduction	Option 2 Bi Weekly Deduction	Option 3 HSA Bi Weekly Deduction
Employee Only	☐ **$54.60**	☐ **$54.74**	☐ **$18.22**
Two Person	☐ **$275.35**	☐ **$276.21**	☐ **$209.15**
Family	☐ **$475.61**	☐ **$477.11**	☐ **$382.36**

Dental – BCBST

Bi-Weekly Deduction

- ☐ Employee Only **$12.31**
- ☐ Employee + 1 **$24.63**
- ☐ Family **$38.90**

Vision – BCBST

Bi-Weekly Deduction

- ☐ Employee Only **$2.81**
- ☐ Employee +1 **$5.61**
- ☐ Family **$8.98**

Basic Life – USAble

- ☐ I wish to continue the basic life insurance coverage at **$0.00** Bi-Weekly Deduction.
- ☐ I want to drop the basic life insurance coverage.

All eligible employees will be automatically enrolled in Teledoc. Be sure to follow registration instructions on the Open Enrollment Presentation. If you are dropping coverage or do not wish to enroll in coverage, please complete the waiver box below.

WAIVER

I understand that I have been offered, and have declined, coverage sponsored by my employer. I understand that by waiving coverage, I may not be able to enroll for coverage until open enrollment in 2021. Reason for waiving coverage:

- ☐ Covered as a dependent on another plan (spouse or dependent child)
- ☐ Covered on a State Plan; Exchange Plan, Medicare, Medicaid or other State Assistance Plan
- ☐ Declining unwanted coverage although I understand there is a Federal tax penalty

☐ Medical	☐ Dental	☐ Vision	☐ Life

Sign here only if you are waiving coverage

Signature: _____ Date: _____

For more information, please visit the Employee Benefits Document Warehouse at
www.rbabenefits.com/mywilkinsbenefits

Please complete page 2, if you are enrolling a dependent on any of your plans for the first time. Return all forms to Becky Keller.

By signing below I authorize WRS to make the appropriate payroll deductions for my benefit elections and I acknowledge receipt of the important employee notification document (All in One Notice) and Summary of Benefits & Coverage (SBC) as required by law from Wilkins Research Services.

Employee Name: _____ **Signature:** _____

Home Address: _____ **Phone Number:** _____

EMPLOYEE NAME_____

Medical – BCBST

Dependent Name: _____ **DOB** _____ **Social Security #** _____

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Dental – BCBST

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Vision – BCBST

Dependent Name: _____ **DOB** _____ **Social Security #** _____

Dependent Name: _____ **DOB** _____ **Social Security #** _____

Dependent Name: _____ **DOB** _____ **Social Security #** _____

Dependent Name: _____ **DOB** _____ **Social Security #** _____

EMPLOYEE NAME_____

HR use only:

Payroll notified of:

- ☐ **medical deduction**
- ☐ **dental deduction**
- ☐ **life deduction**
- ☐ **BCBST Vision**
- ☐ **USAble (life) form completed and faxed (if new enrollee or change too existing):**
- ☐ **Teledoc, if FT eligible confirm enrollment entered**
- ☐ **Date enrollment entered:**
- ☐ **Census updated:**