2025 Hi-Line Benefits Enrollment/Change Form

January 1, 2025 – December 31, 2025

For Internal Use Only:		
Group # H870054		**Location:**
Date of Hire:	**Effective Date:**	**Plan:**

Enrollment (check reason):	☐ New Team Member ☐ Rehired/Reinstatement ☐ Annual Enrollment
Change (check reason):	☐ Court Order ☐ Change Address ☐ Add/Remove Dependent ☐ Dependent Status Change
Change Date: _____	☐ Other: _____
Status Change Event:	☐ Marriage ☐ Birth ☐ Divorce ☐ Death ☐ Loss of Coverage
Event Date: _____	☐ Separation/Reduction In Hours ☐ Adoption/Adoptive Placement

Section 1 - Team Member Information (Please print above lines)

Last Name	First	MI	Date of Birth (Mo Day Yr)	Social Security Number
☐ Female ☐ Male			☐ Yes ☐ No	
Gender	Home Phone Number		Other medical coverage?	
Home Address – No. and Street Address	City	State	Zip Code	Email Address

Section 2 - Dependent Information (If you need more space, please list additional dependents on another sheet of paper and attach it to this form.)

	Spouse Last Name	First	MI	Date of Birth (Mo Day Yr)	Gender	Social Security Number	Other medical coverage?
☐ Add ☐ Drop					☐ F ☐ M		☐ Yes ☐ No

	Child Last Name	First	MI	Date of Birth (Mo Day Yr)	Gender	Social Security Number	Other medical coverage?
☐ Add ☐ Drop					☐ F ☐ M		☐ Yes ☐ No
☐ Add ☐ Drop					☐ F ☐ M		☐ Yes ☐ No
☐ Add ☐ Drop					☐ F ☐ M		☐ Yes ☐ No
☐ Add ☐ Drop					☐ F ☐ M		☐ Yes ☐ No

Section 3 - Complete this section if you answered YES to "Other Medical Coverage" for yourself or any dependents.

Name of covered person	Name of other insurance carrier	Effective date of other coverage
Group #	Policy #	

Please attach a list with the above information for additional dependents that have other medical coverage

Section 4 - Select a Benefit and coverage tier - Rates listed below are per month

Medical Coverage

☐ **Decline Medical Coverage**

Standard Plan	**Monthly Cost**
☐ Team Member Only	$241.00
☐ Team Member + 1 dependent	$840.00
☐ Team Member + 2 dependents	$930.00
☐ Team Member + 3 or more dependents	$964.00

H.S.A. Plan	**Monthly Cost**
☐ Team Member Only	$124.00
☐ Team Member + 1 dependent	$597.00
☐ Team Member + 2 dependents	$608.00
☐ Team Member + 3 or more dependents	$629.00

HSA Monthly Contribution Amount $_____

Dental Coverage

☐ **Decline Dental Coverage**

Dental Plan	**Monthly Cost**
☐ Team Member Only	$43.37
☐ Team Member + Spouse	$88.27
☐ Team Member + Child(ren)	$100.07
☐ Team Member + Family	$155.50

I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage. Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain:

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Section 5 – Coverage Conditions

Provisions and Signature

I have read this form and the other materials given to me about my benefits, and certify that the information I have supplied is complete and accurate. I understand that I have been provided this information in order to make an informed benefit election choice and that I, not Hi-Line, Inc. and/or the affiliates (the "Company"), have made the benefit election indicated on this form. I understand and hereby authorize this election to continue in force in subsequent years until such time as I complete a new enrollment form and make changes to the election. I understand that misstatements, misrepresentations, or omissions may result in my coverage being cancelled as of its Hi-Line active date.

I understand that if I decline enrollment in a health plan for myself or my dependents (including my spouse) because of other health insurance coverage, that I may in the future be able to enroll myself or my dependents in this plan, provided that I am eligible for a special enrollment right under the terms of the plan in place at the time of such loss and I request enrollment within 31 days after my other coverage ends. I understand that, if I have a new dependent as a result of marriage, birth, adoption, or placement of adoption, I must add this dependent within 31 days of such event. I understand that if I decline enrollment now and have no other health insurance coverage, do not enroll within 31 days of losing my current health insurance coverage, or enroll within 31 days of a status change event, that I must wait until the next enrollment period.

By signing and submitting this enrollment form, I authorize the Company to deduct from my salary or wages voluntary contributions to Company-sponsored team member benefit programs. I understand that my elections to participate in any coverage on this form are irrevocable for the entire plan year, unless I experience a status change event during the course of the plan year. I understand that in order to make a mid-year election change due to a status change event that I must enroll within 31 days of such event, and if I fail to enroll within that time, I will lose my right to change my election and cannot change my election until the next enrollment period. I understand that my contributions for the coverage on this form (if elected) will be deducted on a pre-tax basis and that I am liable for these deductions pursuant to such authorization. I understand and acknowledge that it is my responsibility to verify that these payroll deductions are correct. Any administrative error made by the Company in honoring such payroll deductions, whether unintentional or inadvertent, does not relieve me of this liability. I agree to notify the Payroll & Benefits Department in writing immediately upon discovering any discrepancy.

I authorize payment of medical benefits to preferred providers, where applicable, for those charges covered by my group insurance benefits. I authorize release, for the term of my coverage, to or by my physician or healthcare provider or TPA of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits. My authorized representative or I may request a copy of this authorization and a photocopy of this authorization shall be considered valid.

If you decline coverage for reasons other than having other health insurance coverage, and you wish to apply for this coverage at a future date, you will then have to comply with the rules governing late applicants.

_____ _____

Signature Date

_____

Print Name