



GUARDIAN ANGEL STAFFING AGENCY, INC.

2024 ELECTION FORM

ALL EMPLOYEES MUST COMPLETE THIS ELECTION FORM

CIRCLE YOUR SELECTION FOR EACH PLAN BELOW OR INDICATE YOUR DESIRE TO WAIVE

<u>ANTHEM MEDICAL INSURANCE</u>	
	<u>MEDICAL WEEKLY PREMIUMS (52 Pays)</u>
Single	
Employee/Spouse	
Employee/Child(ren)	
Family	
Waive Medical (please initial)	
<u>DELTA DENTAL INSURANCE</u>	
	<u>DENTAL WEEKLY PREMIUMS (52 Pays)</u>
Single	\$5.44
Employee/Spouse	\$10.72
Employee/Child(ren)	\$13.18
Family	\$19.35
Waive Medical (please initial)	
<u>DELTA VISION INSURANCE</u>	
	<u>VISION WEEKLY PREMIUMS (52 Pays)</u>
Single	\$1.45
Employee/Spouse	\$2.90
Employee/Child(ren)	\$3.11
Family	\$4.97
Waive Medical (please initial)	



Please provide details for dependents to be covered for the plans below								
	Name	Gender M or F	Date of Birth	Social Security	Address if different	Medical Y or N	Dental Y or N	Vision Y or N
Spouse								
Child								
Child								
Child								
Child								
Child								

COLONIAL Voluntary Products

	Benefit Amount	Weekly Premium
Voluntary Critical Illness		
Employee		
Employee/Spouse		
One-Parent Family		
Two-Parent Family		
Voluntary Accident		
Employee		
Employee/Spouse		
One-Parent Family		
Two-Parent Family		
Voluntary Short-Term Disability		

I elect to waive the Voluntary Critical Illness (initials) _____ Waive Accident _____

I elect to waive the Voluntary Short-Term Disability (initials) _____

I understand that once I make these elections, I cannot change them until December 1, 2024, unless I experience a valid qualifying event. Qualifying events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, or change in spouse's benefits or employment status. I must request all changes within 30 days of one of these events. Before the beginning of each plan renewal year, I will be offered the opportunity to change my election. I understand all eligible benefit deductions will be done on a pre-tax basis unless I request otherwise in writing.

Print Name

Social Security Number

Signature

Date