CASCADE DESIGNS®

EMPLOYEE BENEFIT ENROLLMENT/CHANGE FORM
January 1 – December 31, 2024 Plan Year

SECTION A: Employee Information

Last Name	First Name	MI	Social Security Number	Gender ☐ Female ☐ Male	Marital Status ☐ Married ☐ Single
Street Address			Date of Birth	Annual Salary	Budget Unit
City	State	Zip	Telephone/Cell Number	Occupation	
Personal Email Address				**Location:** ☐ Seattle ☐ Reno	

SECTION B: Employer Paid Benefits – Mutual of Omaha

The following benefits are provided by Cascade Designs at no cost to you:

☒ Employee Life and AD&D Insurance at 1x's annual earnings to a maximum of $50,000 (minimum of $20,000) **(please fill out the beneficiary designation on the back of this page)**

☒ Employee Short Term Disability at 50% of your weekly earnings

☒ Employee Long Term Disability at 60% of your monthly earnings

Date of Hire:

Effective Date:

SECTION C: Employee Paid Benefits (Costs are per paycheck)

MEDICAL – RGA

Level of Coverage (YOU MUST CHECK A BOX): ☐ **Traditional Plan** ☐ **Health Savings Plan**	Traditional Plan	Traditional Plan – Wellness discount*	Health Savings Plan	Health Savings Plan – Wellness discount*
☐ Employee Only	$53.00	$40.50	$12.50	$0.00
☐ Employee & Spouse	$202.50	$190.00	$142.50	$130.00
☐ Employee & One Child	$105.00	$92.50	$58.50	$46.00
☐ Employee & Two or More Children	$141.00	$128.50	$89.00	$76.50
☐ Employee, Spouse & One Child	$254.50	$242.00	$186.50	$174.00
☐ Employee, Spouse & Two or More Children	$290.00	$277.50	$215.50	$203.00
☐ I elect to waive Medical coverage.				

* You must complete the CDI wellness program requirements and submit the Wellness Program Attestation Form to HR to qualify for the discounted premium.

DENTAL – Delta Dental of Washington		VISION – RGA (only if you enroll in a medical plan)	
☐ Employee Only	$5.50	☐ Employee Only	$0.00
☐ Employee & Spouse	$17.50	☐ Employee & Spouse	$0.00
☐ Employee & One Child	$11.50	☐ Employee & One Child	$0.00
☐ Employee & Two or More Children	$20.00	☐ Employee & Two or More Children	$0.00
☐ Employee, Spouse & One Child	$23.50	☐ Employee, Spouse & One Child	$0.00
☐ Employee, Spouse & Two or More Children	$32.00	☐ Employee, Spouse & Two or More Children	$0.00
☐ I elect to waive Dental coverage.		☐ I elect to waive Vision coverage.	

NOTE: These costs will be deducted from your paycheck on a pre-tax basis unless you inform Human Resources differently. IRS Section 125 regulates that you will not be eligible to make changes to your participation in the Employee Benefit Plan until January 1, 2025 (unless you experience a qualified mid-year status change event*). An election to reduce compensation under the Plan will reduce your compensation for Social Security purposes and may result in a reduction of Social Security benefits that you, or your family, may become entitled to in the future.*

HSA CONTRIBUTION (Only if enrolling in Health Savings Plan)

Contributions will be taken out of your paychecks evenly over the applicable time period.

HSA Contribution for January 1, 2024 – December 31, 2024

☐ No contribution ☐ $ _________ per paycheck

NOTE: The maximum annual HSA contribution for 2024 is $4,150/individual or $8,300/family. This includes contributions made by CDI and any contributions you already made in 2024.

Spouse & Child(ren) Information

☐ Spouse	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**

Children (use additional forms if needed to list all covered dependents)

☐ My Child or Spouse's Child	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**
☐ My Child or Spouse's Child	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**
☐ My Child or Spouse's Child	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**
☐ My Child or Spouse's Child	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**
☐ My Child or Spouse's Child	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**
☐ My Child or Spouse's Child	☐Male ☐Female	Last Name	First Name	Social Security Number	Date of Birth	☐**Add** ☐**Drop** ☐**Medical** ☐**Dental** ☐**Vision**

SECTION D: If declining medical plan coverage, please complete this section

Do you or your dependents have coverage under another employer-sponsored health care plan (including COBRA coverage)? ☐ **NO** ☐ **YES** - If yes, please complete the information below

Name and address of insurer: _____ Identification/Policy #_____

Name of policy holder: _____ Date coverage began: _____

Family members covered (list all): _____

Type of Coverage (check all that apply): ☐ **Medical** ☐ **Dental** ☐ **Vision**

SECTION E: Current/prior coverage information

Please indicate for each person listed on this application any health insurance (including Medicare and Medicaid) in effect within the 24 month period prior to the proposed effective date of coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate none. If you are covered under another medical or dental benefit policy and this coverage will continue, your benefits through Cascade Designs are considered your primary benefits and your other benefit coverage is secondary.

Applicant's Name	Insurance carrier, Policy Number and Phone Number	Date of Coverage From and To	Will coverage continue?	Type of Coverage	Type of Product
			☐ Yes / No ☐	☐ Group ☐ Individual	☐ Medical ☐ Dental
			☐ Yes / No ☐	☐ Group ☐ Individual	☐ Medical ☐ Dental
			☐ Yes / No ☐	☐ Group ☐ Individual	☐ Medical ☐ Dental
			☐ Yes / No ☐	☐ Group ☐ Individual	☐ Medical ☐ Dental

SECTION F: Employer paid Life/AD&D beneficiary information

This beneficiary designation applies to your employer paid Life/AD&D only. If you are enrolled in the optional Life/AD&D please also complete the beneficiary section in the Mutual of Omaha Optional Life/AD&D enrollment paperwork.

PRIMARY Beneficiary Designation (If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.)

	Name	Phone #	Relationship	Street address, city, state, zip code	%
1.					
2.					
3.					

CONTINGENT Beneficiary Designation (Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive)

	Name	Phone #	Relationship	Street address, city, state, zip code	%
1.					
2.					
3.					

Release & Authorization

I hereby apply for coverage under the contracts between the administrators and insurance carriers (RGA and Mutual of Omaha) and my employer, and I agree with the terms of the contracts. I also apply for the same coverage for my spouse and/or my dependent children listed on this application. I certify that my listed dependents and I meet all the eligibility criteria set forth in the benefit guide, dependent eligibility verification form, plan documents and/or contract. I further understand that it is my obligation to notify Human Resources when my spouse or child no longer meets the eligibility requirements described under the Plan. Once a person does not meet the Plan definition of a spouse or dependent child (e.g. due to divorce) they are no longer eligible for benefits. I understand that false or inaccurate information (including misrepresentation of dependent status) and failure to notify my employer that my dependent(s) no longer meet the dependent definition may result in the termination of coverage, non-payment of benefits, recovery of ineligible benefit payments from me or my healthcare providers, termination of employment and/or legal action. I authorize the payroll deductions for health insurance coverage noted in Section C.

☐ By checking this box and typing my name below, it is my intent to electronically sign and electronically submit this form. I understand that by checking this box and typing my name below, I will be applying my electronic signature to this form and that I will be bound with the same force and effect as if I had signed this form on paper by hand.

_____ _____

Employee Signature **Date**