The Mustard Seed

Name:	SSN:
Date of Birth:	Zip Code:

Payroll Deduction Amount (26 pays)

	Medical	Dental	Vision
Employee Only	☐	☐ $ 5.47	☐ $1.66
Employee + Spouse	☐	☐ $16.84	☐ $4.99
Employee + Child(ren)	☐	☐ $19.34	☐ $5.05
Family	☐	☐ $32.24	☐ $9.48
Waiver	☐	☐	☐

If waiving all coverage please CIRCLE reason: Other coverage, on spouse's plan, on parent's plan, on Medicare, Cost, Or Other_____

I UNDERSTAND THAT:

I elect the plans as indicated above and the costs associated with them. I also understand that once I make this election, I cannot change it until the next open enrollment, unless I have experienced a qualifying life event, such as loss or gain of coverage through spouse, parent or government plan; loss of eligibility of a covered dependent; death of a covered dependent; birth or adoption of a child; marriage, divorce or legal separation; change from part-time to full-time status.

I hereby authorize my employer to reduce my cash compensation by the amount indicated above for each **pay period** during the year following the effective date of 12/01/2022 per this agreement.

Signature _____ Date _____

AssuredPartners