KNOX THEOLOGICAL SEMINARY

BENEFITS ENROLLMENT/CHANGE FORM

Effective Date: _____

SEMI-MONTHLY PAYROLL – January 1, 2027 Thru December 31, 2027

A. APPLICANT'S INFORMATION – PLEASE PRINT

Employee Social Security Number	Employee Name (Last, First, Middle Initial)	Date of Birth / /	Gender	Occupation

Employee Home Address (Number, Street, Apt.)	City, State & Zip	Date of Hire / /	Annual Salary $	Location & Class

B. BENEFITS SELECTION

Medical Tier Coverage	Medical – Aetna HDHP HSA	COPAY BASE	SILVER	GOLD
EE. Only	❑ $ 62.23	❑ $ 96.50	❑ $122.89	❑ $144.61
EE. + Spouse	❑ $185.44	❑ $352.65	❑ $405.17	❑ $448.37
EE + Child(ren)	❑ $158.06	❑ $295.72	❑ $342.43	❑ $380.86
EE. + Family	❑ $263.85	❑ $515.64	❑ $584.79	❑ $641.68

❑ Waive Coverage Physician Provider *(required)* _____

❑ HSA Contribution Amount: _____

GAP Tier Coverage	GAP - TransAmerica $500/$500	$2,000/$2,000
EE. Only	❑ $9.25	❑ $25.68
EE. + Spouse	❑ $20.73	❑ $55.17
EE + Child(ren)	❑ $13.40	❑ $40.06
EE. + Family	❑ $20.97	❑ $66.95

❑ Waive Coverage

Dental Tier Coverage	Dental & Vision Guardian DHMO MDG	PPO W7	Davis Vision
EE. Only	❑ $0.00	❑ $ 0.00	❑ $0.00
EE. + Spouse	❑ $0.00	❑ $17.43	❑ $1.55
EE + Child(ren)	❑ $0.00	❑ $24.02	❑ $1.64
EE. + Family	❑ $0.00	❑ $34.96	❑ $3.92

❑ Waive Dental

DHMO Provider *(required)* _____

❑ Waive Vision

C. INDIVIDUALS COVERED *(List all individuals for whom you are electing or changing coverage)*

Relationship to Employee	Add / Delete	Name (Last, First, Middle Initial)	Social Security Number	Date of Birth	Gender	Medical	GAP	Dental	Vision
Spouse	☐ Add ☐ Delete		/ /			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep Child	☐ Add ☐ Delete		/ /			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep Child	☐ Add ☐ Delete		/ /			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep Child	☐ Add ☐ Delete		/ /			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep Child	☐ Add ☐ Delete		/ /			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

New Hire: _____ *(effective date)*

☐ Birth/Adoption ☐ Over-Age Dependent ☐ Marriage/ Divorce ☐ Leave of Absence ☐ Loss of Coverage ☐ Address Change

☐ Add Dependent ☐ Delete Dependent

☐ Termination of Employment: _____ ☐ Voluntary ☐ Involuntary

If you get married, you may add your spouse and any eligible dependent within 31 days following marriage. If you divorce, you must terminate spouse coverage within 31 days. Also, you may add new dependents coverage no later than 30 days after the child's birth/adoption. Documentation of these changes is required.

D. GUARDIAN – EMPLOYER PAID BASIC LIFE & AD&D & LONG-TERM DISABILITY	
Employer Paid Basic Life and AD&D	☒ Enrolled
Employer Paid Long Term Disability	☒ Enrolled

E. LIFE INSURANCE BENEFICIARY & CONTINGENT INFORMATION

Primary Beneficiary's Name	Social Security Number	Relationship to You	Date of Birth	Percentage Must Equal 100%
Contingent Beneficiary's Name	**Social Security Number**	**Relationship to You**	**Date of Birth**	**Percentage Must Equal 100%**

F. GUARDIAN – VOLUNTARY LIFE & AD&D

Voluntary Life and AD&D	Requested Coverage Amount			
Employee – Voluntary Life and AD&D Choice of $10,000 Increments / Guarantee Issue $25,000 not to exceed 5x annual salary	☐ Enroll Coverage Amount $_____	☐ No Change	☐ Cancel Coverage	☐ Waive
Spouse – Voluntary Life and AD&D Choice of $5,000 Increments / 50% of employees elected amount	☐ Enroll Coverage Amount $_____	☐ No Change	☐ Cancel Coverage	☐ Waive
Child(ren) – Voluntary Life and AD&D $10,000 - 14 days to 6 months $10,000 6 months to age 19 (or 26 if a full-time student)	☐ Enroll Coverage Amount $10,000	☐ No Change	☐ Cancel Coverage	☐ Waive

❑ I hereby acknowledge acceptance of the benefits offered to me and authorize payroll deductions to be taken in payment for any benefits I have chosen to enroll in during this plan year. I also acknowledge that enrollment in the Section 125 Pre-Tax plan is for the entire plan year and I may NOT change my coverage elections during this plan year without a qualifying event.

❑ I decline/waive coverage. I have other coverage thru ❑Spouse / ❑Medicare/Medicaid / ❑COBRA / ❑VA Eligibility / ❑Other / ❑Tri-Care/Military

Employee Signature:_____ Date: _____