

**McGuire and Hester
Benefit Election Form 1/01/12 thru 12/31/12**

Employee Name	Date of Hire
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ELECTION TO PARTICIPATE

I hereby elect to participate in the McGuire and Hester Benefit Program. The eligible benefit I wish to receive through salary reduction is set out below (based on 52 pay periods):

PLAN CHOICES	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="checkbox"/> Anthem Blue Cross Solution \$3500 PPO <input type="checkbox"/> Kaiser Deductible Plan <input type="checkbox"/> Kaiser HMO Plan	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
Assurant GAP Plan	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
Direct Dental Dental and Vision	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
Mutual of Omaha Voluntary Life and AD&D post-tax deduction	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
Mutual of Omaha Voluntary Short Term Disability post-tax deduction	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
Section 125 Flex Spending Pre-tax deduction	<input type="checkbox"/> Annual FSA Election \$ _____ (minimum \$500/maximum \$5000) <input type="checkbox"/> Annual Dependent Care Election \$ _____ (minimum \$500/maximum \$5000)			

McGuire and Hester and I agree that the above-designated amount shall be processed through payroll deductions. By this agreement between McGuire and Hester and myself, I understand the following provisions of the McGuire and Hester Benefit Program:

1. The above election applies to the Plan Year 1/01/12 to 12/31/12 and may not be changed except upon a change in my family status such as: marriage, divorce, death of a spouse or child, birth of a child, or change in spouse's employment such as termination. I have 30 days from the date of the change to submit the appropriate change forms to the McGuire & Hester Human Resources Department.
2. I have been made aware of and understand that all of the appropriate documents relating to the McGuire and Hester Benefit Program including the Summary Plan Description, Rate Sheet, Privacy Notice, Initial COBRA Notice and any other relevant Plan Documents or Notices are available to me and my dependents electronically through McGuire and Hester Intranet or the broker web site at www.filice.com/benefits/mcguirehester. I also understand that if I wish to receive a paper copy of any of the above documents, I may do so free of charge by contacting my Human Resources Department .

Employee Signature: _____ **Date:** _____

WAIVER OF PARTICIPATION (OPT out option):

I am electing to waive coverage. I understand that my monthly OPT out cash benefit will be paid on a post tax basis.

Monthly OPT out amount \$ _____ (80% of the "lowest" single premium for your age category or \$350, whichever is less)
 Read OPT out summary to determine your OPT out amount.

If I wish to participate with the McGuire & Hester benefits program at a later date, I must wait until the next Plan Year, unless there is a change in my family status (e.g. marriage, birth of a child, etc.) at which time I can then enroll in the plan.

If I enroll with the McGuire & Hester benefits program during the year due to a change in family status, I understand that my OPT out cash payments will stop.

Employee Signature: _____ **Date:** _____

