



Hourly Employees and Managers

2025-2026 Benefits Form

Plan Year Start Date October 1, 2025

Plan Year End - September 30, 2026

Open enrollment is the only time when you can make enrollment changes, drop coverage, or add/delete dependent(s) from your coverage, unless a qualified change in family status occurs. All elections remain in effect for the duration of the plan year.

IMPORTANT: This form needs to be completed by all benefit eligible employees.

This enrollment form alone does not secure your coverage. Once you select the coverages you want, you will have to fill out enrollment forms and return them to the office ASAP.

Store # _____ Employee Name: Last _____, First _____ Effective Date: 10/01/25

Coverage Level	Highmark PPO		Highmark QPPO		Guardian Voluntary Life Insurance		
	\$500/ \$1000 deductible		Bronze Plan		Units	Cost	Total
Individual	\$120.00		\$42.97				
Emp/ Spouse	\$488.38		\$529.61				
Emp/ Child	\$183.27		\$367.30				
Emp/ Children	\$289.85		\$520.02				
Emp/ Family	\$664.22		\$696.70				

Section 125 Election: Pre-Tax ☐ Post-Tax ☐							
Coverage Level	Guardian Dental		Highmark Vision		Totals		NABCO Disability
Individual	\$10.64		\$2.75		Medical	\$	Managers Only This coverage is for the employee only. It is employer paid, please check this box if you would like to enroll ☐
Emp/ Spouse	\$33.20		\$6.33		Dental	\$	
Emp/ Child	\$33.20		\$6.33		Vision	\$	
Emp/ Children	\$33.20		\$6.33		Life	\$	
Emp/ Family	\$33.20		\$6.33		Total	\$	

Only complete the below section if you are opting to waive health insurance coverage

Waiver of Health Insurance Coverage

I have been informed and acknowledge that I am eligible and have been offered the opportunity to purchase health coverage under my employer's health benefit plan issued by Health Now (HNAS) I decline enrollment at this time because:

- ☐ I have coverage through my spouse's employer
- ☐ I have other coverage
- ☐ I have Medicare coverage
- ☐ I do not wish to enroll myself in any type of medical coverage at this time
- ☐ I do not wish to enroll my ☐ Spouse or ☐ Child(ren) at this time

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may: under certain circumstances in the future, enroll yourself or your dependents in the company's plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. If you have a new dependent, as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed application within 60 days after the marriage, birth, adoption, or placement for adoption

Signature: _____

Date: _____