Hill Laboratories
Since 1945

Benefits Election Form
Plan Year Start Date: April 01, 2026
Plan Year End: March 31, 2027

If you are a Full-Time Employee working 30 hours a week, you are eligible to participate in the medical benefit programs.

If you are a Full-Time Employee working 40 hours a week, you are eligible to participate in the dental and vision benefit programs.

If a dependent is eligible for benefits through their own employer, they are not eligible to enroll in Hill Laboratories' benefits.

New hires are eligible for benefits after 30 days of employment. Payroll deductions will start on the first pay after your effective date.

A. EMPLOYEE / DEPENDENT INFORMATION			
Name:		Social Security:	
Address:		Date of Birth:	
		Date of Hire:	
Phone:		Gender:	Effective Date:
Dependent Name	Gender	Date of Birth	Social Security Number
Spouse:			
Child:			
Child:			
Child:			
Child:			

B. EMPLOYEE WEEKLY MEDICAL CONTRIBUTION			
	OAP Base Plan	OAP Mid Plan	OAP Buy-Up Plan
☐ Employee Only	$28.34	$36.41	$53.27
☐ Employee & Spouse	$30.73	$49.29	$88.08
☐ Employee & Child(ren)	$48.58	$62.97	$93.03
☐ Employee & Family	$75.55	$99.22	$148.69
☐ Waive all Medical Coverage - I understand that my dependents and I will not be covered under my employer's group medical insurance.			

C. EMPLOYEE WEEKLY DENTAL CONTRIBUTION	
☐ Employee Only	$8.69
☐ Employee & Spouse	$18.33
☐ Employee & Child(ren)	$19.18
☐ Employee & Family	$30.75
☐ Waive all Dental Coverage - I understand that my dependents and I will not be covered under my employer's group dental insurance.	

D. EMPLOYEE WEEKLY VISION CONTRIBUTION	
☐ Employee Only	$1.74
☐ Employee & Spouse	$3.55
☐ Employee & Child(ren)	$3.46
☐ Employee & Family	$5.54
☐ Waive all Vision Coverage - I understand that my dependents and I will not be covered under my employer's group vision insurance.	

E. AUTHORIZATION

I have been provided with information relating to the medical benefits. Furthermore, I confirm that I have reviewed this information and understand it. I authorize Hill Laboratories to reduce my salary by the agreed upon amounts indicated on this form to pay premiums for myself and/or my dependents on a pre-tax basis for the coverage I selected above. I understand that due to provider and/or IRS regulations, my coverage elections are binding until either my employer changes the plan or the duration of the plan year, whichever comes first. I understand that I may only change my coverage elections during the 2026-2027 employee benefit plan year if I experience a Qualifying Life Event unless my employer changes plan options offered. I understand I must report any change in family status that may impact my insurance coverage within 30 days of the Qualified Life Event.

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Signature Date