Community Living Experiences, Inc.

2026 Benefits Election Form

EMPLOYEE INFORMATION

Employee Name (Please print clearly)					
Steet Address (ID Cards will be mailed to this address)					
City		State		Zip Code	
Social Security Number					
Date of Birth					
Email		Phone #			

Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Waive
	Weekly Payroll Deductions				
Medical	❑ $55.19	❑ $544.23	❑ $288.90	❑ $801.04	❑
Dental	❑ $14.56	❑ $29.12	❑ $32.42	❑ $51.01	❑
Vision	❑ $3.00	❑ $5.98	❑ $6.41	❑ $10.68	❑
Accident Insurance	❑ $3.81	❑ $6.26	❑ $7.05	❑ $11.08	❑
Hospital Indemnity	❑ $6.84	❑ $13.89	❑ $10.15	❑ $17.78	❑
Critical Illness Coverage	❑ Employee	❑ Spouse	❑ Child(ren)		❑
Critical Illness Coverage Amount	$ _____	$ _____	$ _____		
Group Life Insurance	Community Living Experiences offer you, at no charge, a $15,000 Life Insurance policy. Check the box if you do not want this free benefit.				❑
Voluntary Life Insurance	❑ Employee $_____	❑ Spouse $_____	❑ Child(ren) $_____		❑

Please indicate the amount of coverage you are requesting. The following amounts are available at the guaranteed-issue level; meaning no additional paperwork is required:

Employee: $100,000
Spouse: $30,000
Children: $10,000

Any amounts **above** the guaranteed-issue limit will require additional insurability documentation.

NOTE: As we are with a new Life Insurance provider,
you must re-elect Life insurance even if you currently have it.

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DEPENDENT INFORMATION

Last Name, First Name	Social Security Number (xxx-xx-xxxx	Sex	Date of Birth (MM-DD-YYYY)	Relationship (Self / Spouse / Child)	Coverage
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision

SIGNATURE

Applicant Name (please print): _____

Applicant Signature: _____ **Date:**_____

Ohio Required Statement: Any person who submits an application or a claim containing a false or deceptive statement and does so with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, is guilty of INSURANCE FRAUD.

AUTHORIZATION AND AGREEMENT: I understand this authorization revokes any previous salary reduction agreement for medical, dental and vision insurance. I further understand that this authorization will remain in effect for all future plan years unless revoked or modified. I authorize my employer to deduct my share of the cost, for the coverage elected, on a pre-tax basis (some benefits are not eligible for pre-tax). I understand that the cost to me for coverage will be deducted from my gross earning prior to calculation of certain taxes to be withheld each pay period. I understand these payroll deductions cannot be adjusted during the Plan Year unless I experience a change in family status or other qualifying event as described in section 125 of the IRC and in the applicable Summary Plan Description. Any qualifying events must be submitted to Human Resources within the first 30 days of the event date. Employees participating in medical and/or dental and/or vision plans who go on unpaid leave status will be required to make payments toward their insurance premiums.