Wolfchase Honda - Nissan

EMPLOYEE BENEFITS ELECTION FORM

INITIAL ENROLLMENT ☐; OPEN ENROLLMENT ☐; *OR* SPECIAL ENROLLMENT ☐ ---- LOSS OF OTHER COVERAGE DATE_____ (IF SPECIAL ENROLLMENT)

A. EMPLOYEE INFORMATION

Social Security Number	Last Name	First Name	M.I.	Date of Birth	Gender ☐ Male ☐ Female
Home Street Address Apt.		Home/Cell Phone	Hours worked per week		
City, State, Zip		Date of Hire	Salary/Hourly pay		Job Title

B. MEDICAL PLAN – BLUECROSS BLUESHIELD OF TN

Please make your selection below

☐ Plan #1 ☐ Plan #2 *or* ☐ Plan #3 *with* **Weekly Deduction of $_____**

☐ Employee Only ☐ Employee + Spouse
☐ Employee + Child/Children ☐ Family

☐ I **waive** medical coverage (Other medical coverage? ☐ Yes ☐ No)

C. DENTAL – DEARBORN NATIONAL

Please make your selection below

☐ Plan #1 *or* ☐ Plan #2 *with* **Weekly Deduction of $_____**

☐ Employee Only ☐ Employee + One Dependent
☐ Employee + Two or more Dependents

☐ I **waive** dental coverage (Other dental coverage? ☐ Yes ☐ No)

IF WAIVING MEDICAL or DENTAL COVERAGE, REFER TO THE HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS ON THE BACK OF THIS FORM

D. DISABILITY PLAN – UNUM

Please make your selection below

☐ Short-Term Disability Coverage
☐ Long-Term Disability Coverage
☐ Both Short-Term & Long-Term Disability Coverage
with **Weekly Deduction of $_____**

☐ I **waive** Disability coverage

E. VOLUNTARY LIFE and/or AD&D – UNUM

Please make your selection below by entering your elected benefit amounts

	Amount of Life Coverage	Amount of AD&D Coverage	Weekly Deduction
☐ Employee	$_____	$_____	$_____
☐ Spouse	$_____	$_____	$_____
☐ Child/Children	$_____	$_____	$_____

☐ I **waive** voluntary life coverage

F. FAMILY MEMBERS TO BE COVERED

	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender (M/F)	Check box to elect your coverage		
							Medical	Dental	Voluntary Life
Spouse									
Child									
Child									
Child									

G. 401(k) RETIREMENT PLAN

Please make your selection below:

☐ I received information on how to enroll in the **Wolfchase Honda-Nissan 401k Retirement Plan.** *or* ☐ I **waive** participation at this time.

H. BENEFICIARY DESIGNATION for VOLUNTARY LIFE and AD&D

	Name	Relationship	Percentage (%)
Primary			
Contingent			

I understand that I may apply for participation in the plan(s) above at a later date. However, if I do apply later, coverage may not be guaranteed (as medical insurability must be proven for Life and Disability) or I may have to wait until the next "Open Enrollment" date.

For Life and Disability coverage, I understand the effective date of coverage will be delayed if I am not actively at work due to injury, illness or leave of absence or if an eligible dependent is totally disabled on the date the Life or Disability coverage would otherwise become effective.

I certify that all information supplied on this form is true to the best of my knowledge and that I have also read and understand the information provided on the back of this form.

Employee Signature _____ **Date** _____

ENROLLMENT INFORMATION

Acceptance: By signing this form you are certifying that all information supplied on this form is true to the best of your knowledge. You understand that all benefits for yourself and your eligible dependents will be provided in accordance with the plan contract. You agree to abide by the terms and conditions governing membership and receipt of health services covered by the plans in which you have enrolled. You authorize your employer to reduce your salary for the **Medical Plan (only)** on a pre-tax basis (per IRS regulation Section 125) in an amount necessary to pay for your benefit elections. You understand that your salary reduction cannot be revoked or changed unless you experience a "Change in Status" that allows a change in your election. If you experience a change in status, you may be able to make certain changes to your benefits that fall under the Sec 125 regulation. Your benefit change must be consistent with the status change and should be requested in writing within 30 days of the event. Additional paperwork may be required from you at that time. This signature is also to verify: (1) the accuracy of the information contained on this form; (2) the beneficiary(ies) you have designated; and/or (3) your decision to decline participation in the Company's benefits program.

Change in Status: If you experience one of the following changes in status, you may be able to make certain changes to your benefits that fall under the Section 125 regulation. Your benefit change must be consistent with the status change and be requested in writing within 30 days of the event. Additional paperwork may be required from you at that time.

- Change in employee's legal marital status: Marriage, divorce, legal separation, death of spouse
- Change in number of dependents: Birth, adoption, placement for adoption, death of dependent
- Change in employment status of employee or spouse: Termination, commencement of employment, coverage of spouse, loss or gain of benefit eligibility of spouse
- Dependent eligibility changes: Dependent is new dependent and is no longer eligible
- Residence change of an employee, spouse of dependent
- Material benefit change of employee or spouse
- Change due to entitlement to Medicare or Medicaid
- Change due to anticipated enrollment in Qualified Health Plan: Eligibility for a Special Enrollment in a Qualified Health Plan through a competitive marketplace established under § 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange
- Change due to judgment, decree or other order resulting from divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact La Shay Bailey-Bell at Wolfchase Nissan.

BENEFICIARY DESIGNATION FORM

Wolfchase Honda-Nissan
Retirement Plan

Plan Number: 876391

Request Type ☐ Initial Designation ☐ Change to Designation

Participant Information

Name (first, middle initial, last)	Social Security Number - -	☐ Married ☐ Single

Beneficiary Information

Subject to the terms of my Employer's Plan, I request that any sum becoming due upon my death be payable to the beneficiary(ies) designated below. I understand this designation shall revoke all prior beneficiary designations made by me under my Employer's Plan. *(All designations must be in whole percentages. Total percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary, if designated.)*

1. Beneficiary Name (complete legal name required)	Relationship	☒ Primary Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
2. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
3. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
4. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
5. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)
6. Beneficiary Name (complete legal name required)	Relationship	☐ Primary Beneficiary ☐ Contingent Beneficiary	Percentage
Address and Phone #	Social Security Number		Date of Birth (mm/dd/yyyy)

Fold and tear on perforation

Unless otherwise requested:

1. If more than one beneficiary is designated, payment will be made in equal shares to the primary beneficiaries who survive the participant or annuitant or, if none survives the participant or annuitant, in equal shares to the contingent beneficiaries who survive the participant or annuitant.
2. If no beneficiary survives the participant or annuitant, payment will be made to the executors or administrators of the estate of the participant or annuitant.
3. If a class of beneficiaries is designated (such as, *"the children of the participant or annuitant"*), then payment will be made in equal shares to each person who is a member of the class and living at the death of the participant or annuitant whether or not he/she has been specifically named in the beneficiary designation.
4. If you name an Estate or Trust as beneficiary, contact your Plan Administrator for more information.

Beneficiary Designation Form (continued)

Wolfchase Honda-Nissan
Retirement Plan
Plan Number: 876391

Name (first, middle initial, last)	Social Security Number - -

Certification

- ☐ I am not married at the time I am making this beneficiary designation. I understand that if I later marry, I must submit a new designation naming my spouse as beneficiary, unless he or she agrees in writing to a different beneficiary.
- ☐ I am married and have named my spouse as sole/primary beneficiary.
- ☐ I am married and have named someone other than my spouse as sole/primary beneficiary and my spouse agrees to such designation (spouse must also sign below in the presence of a Notary Public or Plan Representative).

Participant's Signature	Signed in City/Town and State	Date (mm/dd/yyyy)

Witness' Name	Witness' Signature

Spousal Consent

This is to certify that I am the spouse of the above named participant and agree with the beneficiary designation. I understand that the above designation specifies the only person(s) who will receive any death benefits payable in the event of death of the participant.

Spouse's Name	Social Security Number

Spouse's Signature	Date (mm/dd/yyyy)

State of _____, County of _____
On this _____ day of _____, in the year of _____, before me, _____ the undersigned officer, personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed for the same purpose therein contained.
In Witness Whereof, I hereunto set my hand

_____ or _____
Notary Public Plan Representative

Please complete this form and return it to your Plan Administrator.