BENEFIT/CHANGE ELECTION FORM

Plan year: January 1, 2026 – December 31, 2026

BROWN & CONNERY, LLP
ATTORNEYS AT LAW

1. EMPLOYEE INFORMATION

Name (please print):	Employee Number:	Social Security Number:	Gender:
Address:	Date of Birth:	Date of Hire:	
City:	State:	Zip:	
Home Phone Number:	Cell Phone Number:	Email Address:	
Benefits effective date:			

2. MEDICAL/PRESCRIPTION/VISION INSURANCE: HORIZON/EYEMED

Plan Options	Waive Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
EPO High - 826	☐	☐ $95.00 semi-monthly	☐ $1,259.05 semi-monthly	☐ $848.28 semi-monthly	☐ $1,825.22 semi-monthly
EPO Low - 836	☐	☐ $65.00 semi-monthly	☐ $1,034.41 semi-monthly	☐ $678.64 semi-monthly	☐ $1,548.67 semi-monthly
HDHP w/HSA - 620	☐	☐ $32.50 semi-monthly	☐ $952.03 semi-monthly	☐ $615.37 semi-monthly	☐ $1,438.85 semi-monthly

3. DENTAL INSURANCE: DELTA DENTAL

Plan Options	Waive Coverage	Employee Only	Employee + Spouse	Employee + Child	Employee + Child(ren)	Employee + Family
Dental PPO	☐	☐ $16.85 semi-monthly	☐ $32.01 semi-monthly	☐ $32.01 semi-monthly	☐ $50.55 semi-monthly	☐ $50.55 semi-monthly
Dental DHMO	☐	☐ $10.06 semi-monthly	☐ $17.48 semi-monthly	☐ $19.12 semi-monthly	☐ $19.12 semi-monthly	☐ $30.19 semi-monthly

If electing the Dental DHMO please visit **www.deltadentalins.com** to select a primary care dentist or call Delta Dental at **800-422-4234**.

DHMO Provider Selection: ____

4. Dependent Enrollment Information

First & Last Name	Gender	Relationship (SPOUSE, DP, Child)	Date of Birth (MM/DD/YYYY)	Social Security Number (required)	ADD/CANCEL COVERAGE	Select Plan(s) TO ADD/CANCEL
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental
	☐ Male ☐ Female				☐ Add ☐ Cancel	☐ Medical/Rx/Vision ☐ Dental

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the Plan Year, unless there is a change in family status, under the terms of the Plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through Brown & Connery during the open enrollment period each year and during the year within 30 days of a qualified change in status.

By enrolling in medical/prescription/vision and dental, I am authorizing the Firm to take the necessary contributions from my salary for the benefits in which I have enrolled on a BEFORE-TAX basis. I understand benefits choices will be irrevocable for the coming Plan Year unless I have a change in family status or elect to have my contributions taken from my pay on an AFTER-TAX BASIS. Prior to December 31 of each year, I will be offered the opportunity to elect coverage for the following Plan Year. If I do not complete and return a new Benefit Election Form at that time, I will be treated as having elected to continue all before-tax benefits under the Plan for the following Plan Year.

Employee Signature: _____ **Date:** _____