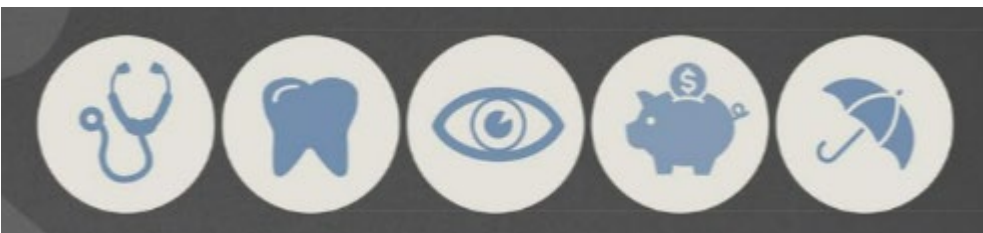


BENEFITS ENROLLMENT FORM

*Benefits supporting your
personal health and
family needs.*

Instructions:

**Please complete,
sign, and date this
enrollment form
and return it to
the Human
Resources
Department
within 31 days of
your date of hire
or within 31 days
of a Qualifying
Life Event.**





BENEFITS ENROLLMENT FORM

Choose One: New Hire Enrollment Qualifying Life Event

Employee Data

Full Name (please print)

Date of Birth

Effective Date

Address

Street

City

State

Zip Code

Qualifying Event Reason(s):

- Name Change Marriage Divorce Death Birth Adoption/Legal Custody
 Court-Ordered Dependent Loss of Coverage Other Life Event – Reason:

Medical Plan (Pre-Tax)

1. Choose your Health Plan Option:

- No Coverage
- United Healthcare – Basic Medical Plan – with Health Savings Account
(Indicate *your* HSA contribution amount below, if applicable**)
- United Healthcare – Core Medical Plan – with Health Savings Account
(Indicate *your* HSA contribution amount below, if applicable**)
- Surest Medical Plan (not eligible for Health Savings Account)

Choose your Level of Coverage:

- Employee Only Employee + Spouse Employee + Child(ren) Family

** VCM will make a monthly contribution, based on the level of elected coverage, to a Health Savings Account through Optum Bank. In addition, if you wish to contribute to the Health Savings Plan, via payroll deduction, please elect your contribution amount below.

- I elect to contribute \$_____ per pay period to my Health Savings Account through Optum Bank (not to exceed the current IRS limits).

Dental Plan (Pre-Tax)

2. Choose your Dental Plan Option:

- No Coverage
- United Healthcare – Dental Plan

Choose your Level of Coverage:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

Vision Plan (Pre-Tax)

3. Choose your Vision Plan Option:

- No Coverage
- United Healthcare – Vision Plan

Choose your Level of Coverage:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

Plan(s) Enrollment Detail – Please complete for all covered participants and plan elections

4. Be sure to check the appropriate boxes for the coverage(s) you elect for you and your dependents; you may add any additional dependents on a separate sheet of paper, if necessary.

NAME (LAST IF DIFFERENT, FIRST, M.I.)	DATE OF BIRTH (MM/DD/YY)	SEX (M/F)	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION	LEGALSHIELD	MASA	GENOMIC LIFE
EMPLOYEE:									
SPOUSE:									
CHILD:									
CHILD:									
CHILD:									

5. Unum Employee Supplemental Life Insurance (after-tax)

Supplemental Life Insurance is in addition to the Basic Life Insurance (2.5x your annual earnings or base salary (whichever is greater) up to a maximum of \$750,000) that Victory Capital Management provides at no cost to you. You must provide evidence of insurability for Supplemental coverage above the guaranteed issue of \$280,000. ***Guarantee Issue amount may differ for a Qualifying Event.*

List amount of coverage from \$10,000 - \$750,000 in increments of \$10,000:

- No Coverage I elect \$_____,000

6. Unum Employee Accidental Death & Dismemberment (AD&D) Insurance (after-tax)

Supplemental AD&D Insurance is in addition to the Basic AD&D Insurance (2.5x your annual earnings or base salary (whichever is greater) up to a maximum of \$750,000) that Victory Capital Management provides at no cost to you.

List amount of coverage from \$10,000 - \$750,000 in increments of \$10,000:

- No Coverage I elect \$_____,000

7. Unum Spouse Life Insurance (after-tax)

List amount of coverage from \$1,000 - \$250,000 in increments of \$1,000. The amount requested cannot exceed the employee covered amount. You must provide evidence of insurability for Supplemental coverage above the guaranteed issue of \$50,000. ***Guarantee Issue amount may differ for a Qualifying Event.*

- No Coverage I elect \$_____,000

8. Unum Spouse Supplemental Accidental Death & Dismemberment (AD&D) Insurance (after-tax)

List amount of coverage from \$1,000 - \$250,000 in increments of \$1,000. The amount requested cannot exceed the employee covered amount.

- No Coverage I elect \$_____,000

9. Unum Dependent Life Insurance (up to age 19, or 26 if fulltime student) (after-tax)

List amount of coverage from \$1,000 - \$10,000 in increments of \$1,000. The amount requested cannot exceed the employee covered amount. ***Guarantee Issue amount may differ for a Qualifying Event.*

- No Coverage I elect \$_____,000 for each dependent child

10. Unum Dependent Supplemental Accidental Death & Dismemberment (AD&D) Insurance (after-tax)

List amount of coverage from \$1,000 - \$10,000 in increments of \$1,000. The amount requested cannot exceed the employee covered amount.

- No Coverage I elect \$_____,000 for each dependent child

Additional Ancillary Benefits

11. Flexible Spending Account – A Navia Enrollment Form will also need to be completed.

- No Coverage
- Limited – I elect \$_____ annual contribution –
Only eligible if enrolled in a High-Deductible Health Plan (Annual Limit for 2024 is: \$4,150)
- Medical – I elect \$_____ annual contribution –
Only eligible if NOT enrolled in a High-Deductible Health Plan (Annual Limit for 2024 is: \$4,150)
- Dependent Care – I elect \$_____ annual contribution –
(Annual Limit for 2024 is: \$5,000)

12. LegalShield – A LegalShield Enrollment Form will also need to be completed.

- No Coverage
- Personal Plan – Single/Family Coverage \$8.54/per pay
- Personal/Business Plan – Single/Family Coverage \$15.44/per pay

13. MASA Emergency Transportation – A MASA Enrollment Form will need to be completed.

- No Coverage
- Emergent Plus (US & Canada) – Single/Family Coverage \$6.46/per pay
- Platinum (Worldwide) – Single/Family Coverage \$18.00/per pay

14. Genomic Life – A Genomic Life Enrollment Form will need to be completed.

- No Coverage
- Employee Only (monthly rates by age shown below)
- Employee & Spouse (monthly rates by age shown below)

	EE Only	EE & SPOUSE
Up to Age 50	\$18	\$36
Age 50-64	\$22	\$44
Age 65+	\$26	\$52

Acknowledgement

15. Signature

I certify below that I have completed this form to the best of my knowledge, and I understand the following:

- My coverage elections on this form cannot be revoked or modified during the year (with the exception of the Health Savings Account (HSA) unless I have a qualifying change in status as defined by the IRS; however, I may change my coverage elections during the next open enrollment period.)
- My pay will be reduced by the amount of any contributions noted for the coverage(s) elected where the contributions are pre-tax.

Signature

Date