2019- 2020 BENEFITS ENROLLMENT FORM

Plan Year Start Date: April 1, 2019
Plan Year End Date: March 31, 2020

INSTRUCTIONS

Your benefit options are identified in the following sections. Please review your options carefully. When you have decided what benefits best fit your needs, you can enroll online at www.CTDIbenefits.com or submit your completed enrollment form to the Employee Benefits Service Center via fax at 1-866-406-6946 or via mail using the enclosed business reply envelope. **All benefits elections must be submitted within 31 days of your effective date (listed below).** Please call **1-800-307-0230** if you have any questions or need assistance.

EMPLOYEE PROFILE

Name: ______________________ **SSN:** ______________________

Address: ______________________ **Date of Hire:** ______________________

______________________ **Date of Birth:** ______________________

Health Benefits (Medical/Prescription/Vision/Dental)

COVERAGE LEVEL	SELECT BUNDLE	CHOICE BUNDLE
Employee Only	☐ $38.75	☐ $19.50
Family	☐ $97.00	☐ $48.50

Contribution Taxability:

☐ I want my health benefit premium deducted on a "PRE-TAX" basis

☐ I want my health benefit premium deducted on a "POST-TAX" basis

WAIVE Health Coverage ☐

HEALTH SAVINGS ACCOUNT (HSA) – *Available Only to Choice Bundle Participants*

If you elect to participate in the Choice Bundle, you may contribute funds to an HSA on a pre-tax basis. HSA participants are now eligible for the CTDI contribution match of up to $250 for single coverage, or $500 for family coverage. The 2019 annual HSA employee contribution maximums are $3,250 for Employee Only coverage and $6,500 for all other coverage levels. If you are age 55 or older, you may elect an additional $1,000 (regardless of the coverage level you elected).

If you are interested in participating in an HSA, indicate your election by checking the box below and listing your annual contribution amount. This amount will be divided among 52 pay periods to determine your contribution per pay period.

☐ **YES**, I would like to participate in an HSA. My **annual** contribution amount is $__________________

DEPENDENT COVERAGE

Dependents who are currently covered under your benefits and continue to meet the eligibility requirements will automatically remain enrolled for the new plan year. You only need to complete this section if you are newly enrolling or removing dependents from coverage. **If you are adding new dependents, you MUST provide the necessary documentation to prove their eligibility in order to have them added to the plan(s). You can find a list of acceptable documentation** online at www.CTDIbenefits.com – there you can also upload your documentation. Please include **all** of the information requested below for those dependent family members who will newly be covered under or removed from your Health and/or Voluntary Life and AD&D Insurance benefits. **Valid Social Security Numbers must be provided at this time.**

Coverage Election Add / Remove	First Name	Last Name	SSN	DOB	Relationship	Gender	Covered Under?*
☐ ADD ☐ REMOVE					SPOUSE	☐M ☐F	☐H ☐L**
☐ ADD ☐ REMOVE					CHILD	☐M ☐F	☐H ☐L**
☐ ADD ☐ REMOVE					CHILD	☐M ☐F	☐H ☐L**
☐ ADD ☐ REMOVE					CHILD	☐M ☐F	☐H ☐L**
☐ ADD ☐ REMOVE					CHILD	☐M ☐F	☐H ☐L**
☐ ADD ☐ REMOVE					CHILD	☐M ☐F	☐H ☐L**

*H = Health Benefits, L = Voluntary Life and AD&D Insurance **Please note that if you elect to cover a child under the Voluntary Life Insurance Plan, this benefit will also apply to all of your dependent children.

Dependent Coverage Notes:

- Dependent children up to age 26 are eligible for coverage under the CTDI Employee Benefits Program.
- Employees are required to submit documentation for any dependent enrolled under any CTDI-sponsored benefit plan even if the dependent is only covered under voluntary benefit plans (i.e. Spouse/Child coverage in Life, Critical Illness, or Accident).
- You may be required to provide proof of disability if enrolling a child of any age who is mentally or physically disabled and dependent upon you for support.
- Any false or misleading information provided about yourself and/or dependents as part of the benefits enrollment process may constitute insurance fraud and may be grounds for disciplinary action up to and including termination of employment.

VOLUNTARY LIFE AND AD&D INSURANCE

To elect Voluntary Life and AD&D Insurance, please indicate the coverage amount you wish to purchase in the applicable space below. You may calculate your cost for employee and spouse coverage by logging on to www.CTDIbenefits.com or by calling the Employee Benefits Service Center at 1-800-307-0230. **Please be aware that if you are electing more than the Guaranteed Issue amount during your initial eligibility period, requesting to increase an existing coverage amount or requesting coverage outside of your initial eligibility period, you will be subject to Evidence of Insurability.**

EMPLOYEE		SPOUSE*		CHILD*	
Coverage can be purchased in increments of $10,000 to a maximum benefit of $750,000.		Coverage can be purchased in increments of $10,000 to a maximum of the lesser of $100,000 **OR** 100% of the employee coverage amount.		You may purchase $5,000 or $10,000 of coverage for your dependent child(ren).	
COVERAGE AMOUNT	WEEKLY COST	COVERAGE AMOUNT	WEEKLY COST	COVERAGE AMOUNT	WEEKLY COST
				☐ $5,000	$0.23
$ ____________	$ ____________	$ ____________	$ ____________	☐ $10,000	$0.46
☐ **WAIVE EMPLOYEE Coverage**		☐ **WAIVE SPOUSE Coverage**		☐ **WAIVE CHILD Coverage**	

The question(s) below must be answered in order to obtain coverage.

Have **you** used tobacco products in the last 12 months? ☐ **YES** ☐ **NO**

Has **your spouse** used tobacco products in the last 12 months? ☐ **YES** ☐ **NO**

***You must enroll in Voluntary Employee Life and AD&D Insurance in order to elect coverage for your spouse and/or dependent child(ren).**

VOLUNTARY LONG-TERM DISABILITY (LTD)

Make your Voluntary LTD election by checking the applicable box below. You may calculate your cost for coverage by logging on to www.CTDIbenefits.com or by calling the Employee Benefits Service Center at 1-800-307-0230.

My Election (Choose One)	Description	Weekly Cost
☐ **ENROLL in Voluntary LTD Coverage**	60% of your monthly salary to a maximum monthly benefit of $6,000	$ ________
☐ **WAIVE Voluntary LTD Coverage**	No income replacement benefits	$0.00

VOLUNTARY CRITICAL ILLNESS INSURANCE

STEP ONE: Make Your Coverage Election (Select One).

$20,000 Coverage Level	Weekly Cost
☐ **Employee Coverage**	$ ________
☐ **Employee and Spouse Coverage** (Spouse receives 50% employee benefit)	$ ________
☐ **Employee and Child(ren) Coverage** (Child(ren) receives 50% employee benefit)	$ ________
☐ **Family Coverage** (All dependents receive 50% employee benefit)	$ ________
☐ **WAIVE Voluntary Critical Illness Insurance**	$0.00

$20,000 Coverage Level	Weekly Cost
☐ **Employee Coverage**	$ ________
☐ **Employee and Spouse Coverage** (Spouse receives 50% employee benefit)	$ ________
☐ **Employee and Child(ren) Coverage** (Child(ren) receives 50% employee benefit)	$ ________
☐ **Family Coverage** (All dependents receive 50% employee benefit)	$ ________

STEP TWO: Indicate Whether or Not You Use Tobacco Products. The question below must be answered in order to obtain coverage.
Have **you or any of your covered dependents*** used tobacco products in the last 12 months? **YES NO**
*If you or any of your covered dependents have used tobacco products, the entire family will be charged the smoker rates.

You may calculate your cost for coverage by logging on to www.CTDIbenefits.com or by calling the Employee Benefits Service Center at 1-800-307-0230.

VOLUNTARY ACCIDENT INSURANCE

Make your Voluntary Accident Insurance election by checking the applicable box below.

The Low Plan

Coverage Level	Weekly Cost
☐ **Employee Only**	$3.03
☐ **Employee and Spouse**	$5.24
☐ **Employee and Child(ren)**	$6.55
☐ **Family**	$8.32
☐ **WAIVE Voluntary Accident Insurance**	$0.00

The High Plan

Coverage Level	Weekly Cost
☐ **Employee Only**	$3.79
☐ **Employee and Spouse**	$6.55
☐ **Employee and Child(ren)**	$8.02
☐ **Family**	$10.37

IMPORTANT: Voluntary Life, Voluntary Long-Term Disability, Critical Illness and Voluntary Accident Insurance elections do not become effective unless all covered persons are actively at work on the date of the enrollment and the effective date of coverage.

BASIC LIFE AND AD&D INSURANCE BENEFICIARY INFORMATION

Please indicate your beneficiary designation for your Basic Life and AD&D Insurance benefits in the event of your death. You may indicate a Primary and Contingent Beneficiary. You may also name more than one Primary and/or Contingent Beneficiary. Unless designated otherwise, payment will be made in equal shares or all to the survivor. If you are interested in designating an estate or trust as a beneficiary, please refer to the **Trust and Beneficiary Designation Instructions** posted online at **www.CTDIbenefits.com**.

Beneficiary Type	Name (First, MI, Last)	Address	DOB	SSN	Relationship	% of Benefit (Total Must = 100%)
PRIMARY						
CONTINGENT						

VOLUNTARY LIFE AND AD&D INSURANCE BENEFICIARY INFORMATION

Please indicate your beneficiary designation for your Voluntary Life and AD&D Insurance benefits in the event of your death. **If you would like your Voluntary Life and AD&D Insurance beneficiary(ies) to be the same as you Basic Life and AD&D Insurance beneficiary(ies), please check the box below.** If you would like to elect different beneficiaries for your Voluntary Life and AD&D Insurance benefits you may do so by filling in the table below. If you are interested in designating an estate or trust as a beneficiary, please refer to the **Trust and Beneficiary Designation Instructions** posted online at **www.CTDIbenefits.com**.

☐ **I elect to make my Voluntary Life and AD&D Insurance beneficiary(ies) the same as the Basic Life and AD&D Insurance beneficiary(ies) listed above.**

Beneficiary Type	Name (First, MI, Last)	Address	DOB	SSN	Relationship	% of Benefit (Total Must = 100%)
PRIMARY						
CONTINGENT						

VOLUNTARY CRITICAL ILLNESS INSURANCE BENEFICIARY INFORMATION

Please indicate your beneficiary designation for your Voluntary Critical Illness Insurance benefits in the event of your death. **If you would like your Voluntary Critical Illness Insurance beneficiary(ies) to be the same as you Basic Life and AD&D Insurance beneficiary(ies), please check the box below.** If you would like to elect different beneficiaries for your Voluntary Critical Illness Insurance benefits you may do so by filling in the table below. If you are interested in designating an estate or trust as a beneficiary, please refer to the **Trust and Beneficiary Designation Instructions** posted online at **www.CTDIbenefits.com**.

☐ **I elect to make my Voluntary Critical Illness Insurance beneficiary(ies) the same as the Basic Life and AD&D Insurance beneficiary(ies) listed above.**

Beneficiary Type	Name (First, MI, Last)	Address	DOB	SSN	Relationship	% of Benefit (Total Must = 100%)
PRIMARY						
CONTINGENT						

VOLUNTARY ACCIDENT INSURANCE BENEFICIARY INFORMATION

Please indicate your beneficiary designation for your Voluntary Accident Insurance benefits in the event of your death. **If you would like your Voluntary Accident Insurance beneficiary(ies) to be the same as you Basic Life and AD&D Insurance beneficiary(ies), please check the box below.** If you would like to elect different beneficiaries for your Voluntary Accident Insurance benefits you may do so by filling in the table below. If you are interested in designating an estate or trust as a beneficiary, please refer to the **Trust and Beneficiary Designation Instructions** posted online at **www.CTDIbenefits.com**.

☐ **I elect to make my Voluntary Accident Insurance beneficiary(ies) the same as the Basic Life and AD&D Insurance beneficiary(ies) listed on the previous page.**

Beneficiary Type	Name (First, MI, Last)	Address	DOB	SSN	Relationship	% of Benefit (Total Must = 100%)
PRIMARY						
CONTINGENT						

VOLUNTARY AUTO AND HOME INSURANCE

CTDI employees have the opportunity to receive a group discount on Voluntary Auto and Home Insurance through Liberty Mutual. Coverage types available include auto, homeowners, renters, recreational vehicles, and more. To learn more, please call **1-800-524-9400** or visit **www.libertymutual.com/CTDI** for your free quote. Please mention **client # 122031**.

VOLUNTARY PET INSURANCE

CTDI employees have the opportunity to receive a group discount on pet insurance through Veterinary Pet Insurance (VPI). VPI plans cover thousands of medical problems and conditions related to accidents or illnesses for dogs, cats, birds, ferrets, rabbits, reptiles and other exotic pets. You have the option to choose from a variety of VPI plans based on pet type and the level of coverage required. Enrollment is completed directly with the carrier and can be done online at **www.PetsVPI.com** or by calling **1-877-PETS-VPI**. For more information about this benefit or to request a quote, visit the VPI website.

AUTHORIZATION

I have been provided with information relating to each of the benefit options highlighted above. I have reviewed this information and understand it. I authorize Communications Test Design, Inc. to reduce my salary by the agreed upon amounts indicated on this form to pay premiums for myself and my eligible dependents on a pre-tax or post-tax basis (as indicated on this first page of this form) for the health benefits 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 plan year if I experience a Qualifying Life Event (QLE), examples of which include marriage, adoption/birth of a child, divorce, death of a dependent, termination of spouse's employment, etc., or if my employer changes the plan options offered. I understand that I must report any change in family status that may impact my insurance coverage to the Employee Benefits Service Center within 31 or 60 days (depending on the type of event being reported). I also understand that my employee and employer contributions to Social Security will be somewhat reduced if I choose to have my health benefits deducted on a pre-tax basis.

______________________________ ______________________________

Signature **Date**

END OF FORM