EDUCATION MANAGEMENT & NETWORK, INC

BENEFITS ENROLLMENT & CHANGE FORM

Benefits Plan Year: 11/01/2025 – 10/31/2026

ENROLLMENT TYPE: ☐ Open Enrollment ☐ New Hire ☐ Rehire ☐ Change of Status ☐ Termination

EMAIL: enrollment@44n.com	DIVISION:	*Please **print CLEARLY** and complete **ALL** fields*
NAME:	DATE OF HIRE:	EFF DATE:
SSN:	BIRTH DATE:	☐M ☐F ☐ MARRIED ☐ SINGLE
MAILING ADDRESS:		PHONE:
CITY: ST: ZIP: COUNTY:		EMAIL:
LOCATION: ☐ CANIFF ☐ NEW DAWN ☐ OAKLAND		ANNUAL SALARY:

PLAN ELECTION FORM

Medical Coverage

☐ HAP HMO $500, electing coverage (check box below)
Employee ☐ Two Person ☐ Family ☐Waive coverage
Primary Care Physician (PCP): _____

Dental Coverage

☐ Delta Dental 100/90/60/50, electing coverage (check box below)
☐ Employee ☐ Two Person ☐ Family ☐ Waive coverage

Vision Coverage

☐ VSP Vision 12/12/24, electing coverage (check box below)
☐ Employee ☐ Two Person ☐ Family ☐Waive coverage

Short-Term Disability

☐ Lincoln STD, electing coverage
☒ Employee

	NAME (First, Middle, Last)	SSN	BIRTH DATE	M/F	COVERAGE
Spouse ☐Add ☐ Delete	(1) PCP:			☐ M ☐ F	☐Medical ☐Dental ☐Vision
Dependent ☐Add ☐ Delete	(2) PCP:			☐ M ☐ F	☐Medical ☐Dental ☐Vision
Dependent ☐Add ☐ Delete	(3) PCP:			☐ M ☐ F	☐Medical ☐Dental ☐Vision
Dependent ☐Add ☐ Delete	(4) PCP:			☐ M ☐ F	☐Medical ☐Dental ☐Vision
Dependent ☐Add ☐ Delete	(5) PCP:			☐ M ☐ F	☐Medical ☐Dental ☐Vision

CHANGE OF STATUS – Please check all applicable boxes

This section is only required to be completed if a change is being made outside of the new hire waiting period or open enrollment.

Effective Date: _____

Reason for Change:

☐ Change in Employment Status ☐Loss of Prior Coverage ☐ Marriage ☐ Divorce ☐ Left Employment ☐ Birth

☐ Dependent Aging Out ☐ Other Insurance ☐ Address Change *List new address on front page* ☐ Death

☐ Name Change – Previous Name: _____

COORDINATION OF BENEFITS INFORMATION – if additional space is needed, please attach a sheet

OTHER COVERAGE ☐ YES ☐ NO

SPOUSE'S GROUP INSURANCE OR HMO:	NAME OF SPOUSE'S EMPLOYER:			
MEDICAL COVERAGE	☐ YES ☐ NO IF YES, GROUP #:			TYPE OF COVERAGE
DENTAL COVERAGE	☐ YES ☐ NO IF YES, GROUP #:			☐ SINGLE ☐ FAMILY
VISION COVERAGE	☐ YES ☐ NO IF YES, GROUP #:			☐ SINGLE ☐ FAMILY
MEDICARE ENROLLEES	☐ YES ☐ NO IF YES, GROUP #:			☐ SINGLE ☐ FAMILY
MEDICARE / MEDICAID / OTHER	☐ YOURSELF	MEDICARE #:	☐SPOUSE	MEDICARE #:
MEDICARE / MEDICAID / OTHER	☐ ELIGIBLE DEPENDENT	DEPENDENT NAME:		ID #

Please Sign & Date next page

CERTIFICATION

By signing this form, I certify that these are my benefit elections and that:

1. I understand that having agreed to enroll, that I will have no right to participate in the benefit plans and that these benefits will not be available to me, until I have completed, signed, and returned the enrollment form and my enrollment is accepted.
2. I authorize the "pre-tax" deduction of a portion of my salary based on the benefit coverages I have elected above to be deposited in equal deposits as my personal Benefit Credits until I revoke or replace such and I understand that my share of the cost of the benefits under the group health insurance plan may be adjusted from time to time to reflect the change in rates charged by the carriers.
3. I understand that coverage applies only to expenses incurred during my participation in the plan.
4. I understand that as of the first day of the plan year, this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in my family status as defined in the Plan Documents which includes a change in my employment or spouse's employment status.
5. I understand that pre-tax premiums paid under this Salary Reduction Agreement reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation which is considered for Social Security Purposes.
6. I certify that I will not seek reimbursement for expenses reimbursed by the HRA Plan under any major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Employee Signature: _____ **Date:** _____