2027 BENEFITS OPEN ENROLLMENT FORM

For benefits effective January 1 - December 31, 2027

Medical, Dental, & Vision

PLEASE CHECK ONE:

☐ NEW ENROLLMENT ☐ CHANGES/QUALIFYING LIFE EVENT ☐ NO CHANGES (SKIP TO SIGNATURE SECTION F)

A. EMPLOYEE INFORMATION (PLEASE PRINT)

Name (Last, First, MI): Social Security Number: Date of Hire (mm/dd/yyyy):

Street Address: City: State: Zip:

Home Phone: Work Phone: Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated Date of Birth (mm/dd/yyyy):

Location:

☐ L211 - Cold Storage Pittstown PA ☐ L250 - Cold Storage Lebanon PA

B. MEDICAL PLAN OPTIONS (WEEKLY CONTRIBUTIONS) *Please check (✓) one box*

	GEISINGER PPO PLAN
Employee Only	☐ $67.55
Employee + Spouse	☐ $347.22
Employee + Children	☐ $270.40
Employee + Family	☐ $453.76

☐ **WAIVE MEDICAL COVERAGE**

To be completed by the RLS Human Resources Team:

GROUP #: 10117727 **CLASS ID:** _____

C. DENTAL PLAN OPTIONS (WEEKLY CONTRIBUTIONS) *Please check (✓) one box*

	Principal PPO Base Plan	Principal PPO Buy-Up Plan
Employee Only	☐ $1.09	☐ $2.90
Employee + Spouse	☐ $4.01	☐ $7.73
Employee + Children	☐ $5.47	☐ $12.55
Employee + Family	☐ $8.93	☐ $18.54

☐ **WAIVE DENTAL COVERAGE**

D. VISION PLAN OPTION (WEEKLY CONTRIBUTIONS) *Please check (✓) one box*

	Aetna Vision Plan
Employee Only	☐ $1.53
Employee + Spouse	☐ $2.90
Employee + Children	☐ $3.06
Employee + Family	☐ $4.50

☐ **WAIVE VISION COVERAGE**

E. DEPENDENT INFORMATION - ALL FIELDS REQUIRED *(Indicate dependents that you want covered by your Medical, Dental, and/or Vision plans)*

Name (Last, First, MI)	Gender	Date of Birth	Social Security Number	Coverage
Spouse/Partner	☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision

If enrolling more than four children, please attach a separate sheet of paper with the above information.

F. EMPLOYEE ACKNOWLEDGEMENT

I apply for coverage, as indicated, for which I am or may become eligible through my employment with RLS Logistics. I have read the above statements and represent they are true to the best of my knowledge. If applicable, the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on my for their support. I authorize my employer to deduct from my pay the necessary premiums (if any) to be withheld through payroll deduction and, where allowed, on a pre-tax basis, in equal installments throughout the plan year.

IMPORTANT: DON'T FORGET!

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status. The elections on this form are effective for the plan year of January 1, 2027 - December 31, 2027.

Employee's Signature **Date**

WAIVER OF INSURANCE

I_____, hereby certify that the insurance plans offered by RLS Logistics have been explained and offered to me. However, by my own free will and without coercion, I have decided to waive my enrollment and refuse insurance coverage for myself and my eligible dependents. I further understand that should I want to enroll myself or my eligible dependents for medical, dental, and/or vision coverage in the future, I and/or my eligible dependents will be required to submit proof of coverage loss through another insurance carrier. If documentation is not submitted, enrollment requests will only be accepted during annual open enrollment each year.

Employee's Signature **Date**

EMPLOYER VERIFICATION *(To be completed by employer. Employer signature required)*

Signature Date

Effective Date