R1 RESOURCE 1

Open Enrollment—Benefit Election & Waiver Form

Company Name Resource 1, Inc.

Address _____

Employee Name *(Please Print)* _____

City, State, Zip Code _____

Telephone Number ___ ___ _____

Please complete this election form for your 2019-2020 medical benefits in its entirety. Once the section above is filled out, please indicate:

1) If you are waiving coverage: Fill out the top section of the form and check the box for "I choose to waive medical coverage for myself and my dependents." Then print your name, sign and date the bottom of the form, and email it to Marcy Link in Human Resources at mlink@resource1.com.

2) If you are electing coverage: Fill out the top section of the form, select plan option and tier, and add dependents if applicable. Then print your name, sign and date the bottom of the form, and email it to Marcy Link in Human Resources at mlink@resource1.com.

Medical Coverage

☐ I choose to waive medical coverage for myself and my dependents

BlueCross BlueShield of IL

Election	PPO - MPPE3Q26	HSA - MPPO1Q07
Employee Only	☐ $1,188.11 monthly	☐ $1,001.79 monthly
Employee + Spouse	☐ $2,177.23 monthly	☐ $1,835.81 monthly
Employee + Child(ren)	☐ $2,001.50 monthly	☐ $1,687.65 monthly
Family	☐ $2,990.64 monthly	☐ $2,521.69 monthly

Note: If any election other than Employee Only is chosen, please complete the Dependent Information section below.

Dependent Information — Must be completed if you have any dependents to be enrolled in the medical insurance.

Name	Relationship	Medical
		☐
		☐
		☐
		☐

Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes to your medical insurance will be during the HSA special open enrollment (see HR for details), or at next year's open enrollment period for a 11/1/2020 effective date unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact your local Human Resources representative within 30 days of the life status change.

My signature below authorizes Resource 1, Inc. to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: ___/___/___