2019 BENEFITS ENROLLMENT/CHANGE FORM
Medical, Dental, Vision, HCFSA/DCRA and HSA Coverage

INSTRUCTIONS

Unless specified otherwise, all paperwork required to enroll in your benefits must be received by Human Resources no later than your 31st calendar day of regular, benefit eligible employment. Employees making changes to benefit coverage due to a qualifying event must attach supporting documentation for the qualifying event. All forms must be turned in to Human Resources within **31 calendar days** from the date of the qualifying event.

Type of Enrollment - Select One:

- ☐ **New Enrollment** (New Hire/New Eligibility)
- ☐ **Adding Dependents**
- ☐ **Dropping Dependents**
- ☐ **Other Benefit Changes**

Qualifying Change in Family Status

Date of Change:_____/_____/ _____

- ☐ **Marriage**
- ☐ **Birth/Adoption**
- ☐ **Divorce**
- ☐ **Change in Dependent Eligibility Status**
- ☐ **Gain of other Coverage**
- ☐ **Loss of Other Coverage**
- ☐ **Death**
- ☐ **Other** _____

EMPLOYEE INFORMATION

You must complete this information to enroll in benefits.

	LAST NAME	FIRST NAME	DOB	SSN (REQUIRED)	Gender	Marital Status	Covered Under**
Personal Information					☐M ☐F	☐Single ☐Married	☐M ☐D ☐V
Address	Street		Apt	City	State		Zip
Contact Information	Home Phone			Office Phone		Cell Phone	
Employment Information	Work Site Location/Field Zone					Date of Hire	

*M = Medical Plan, D = Dental Plan, V = Voluntary Vision Plan

DEPENDENT INFORMATION

In order to enroll your eligible dependents you must include the information requested below for all dependent family members who will be covered under the medical, dental and/or vision plan(s). Be sure to check the boxes in the "Covered Under" section for each benefit under which the dependent(s) should be covered. If you do not complete the "Covered Under" section, any qualified dependents will receive the same benefits as you. In addition, you must provide copies of valid supporting documents (e.g. marriage certificate, birth certificate, adoption papers) to your local Human Resources Department upon submission of your enrollment form. A failure to provide this information will result in your dependents being removed from the plan.

Relationship	For Changes Only	LAST NAME	FIRST NAME	SSN (REQUIRED)	DOB	Gender	Covered Under**
SPOUSE	☐ Add ☐ Drop					☐M ☐F	☐M ☐D ☐V
CHILD	☐ Add ☐ Drop					☐M ☐F	☐M ☐D ☐V
CHILD	☐ Add ☐ Drop					☐M ☐F	☐M ☐D ☐V
CHILD	☐ Add ☐ Drop					☐M ☐F	☐M ☐V D
CHILD	☐ Add ☐ Drop					☐M ☐F	☐M ☐D ☐V
CHILD	☐ Add ☐ Drop					☐M ☐F	☐M ☐D ☐V

E = Disabled; *M = Medical Plan, D = Dental Plan, V = Voluntary Vision Plan

IMPORTANT REMINDER ABOUT COVERING YOUR ELIGIBLE DEPENDENTS

Only those dependents that are defined as eligible may be covered under your medical, dental and/or vision benefits. Your eligible dependents include your legal spouse, your children age 26 and under or your dependent disabled child. Standard Motor Products reserves the right to audit the dependents covered under its benefit plans to ensure that they are eligible for coverage.

SMOKER STATUS (PLEASE CHECK ONE)**:** **SMOKER** ☐ **NON SMOKER** ☐

- **MEDICAL SMOKER SURCHARGE**: A 25% fee will be calculated upon the 'Employee Only' contribution. This fee will be added to the total contribution amount (After completing Step One and Two).
- **SMOKER CRITERIA**: A smoker is one that has used tobacco products within the past 60 days

PPO MEDICAL/Rx COVERAGE (Select Coverage Level or Waive Benefit)

COVERAGE LEVEL	**STEP ONE TO CALCULATE CONTRIBUTION AMOUNT** ANTHEM BCBS PPO	
	MONTHLY BASE RATE FOR THOSE EARNING $30,000 AND BELOW ANNUALLY	FIXED RATE FOR THOSE EARNING $30,001 AND OVER ANNUALLY
☐ EMPLOYEE ONLY	$100.00	$100 + 1%
☐ EMPLOYEE + 1	$220.00	$220 + 1.5%
☐ FAMILY (EMP + 2 OR MORE)	$280.00	$280 + 2%
☐ DECLINE MEDICAL BENEFITS	**STEP TWO TO CALCULATE CONTRIBUTION AMOUNT** Multiply by 1.16	

Employees earning $30,000 and below annually will pay monthly base rates of $100, $220 or $280 per month, based on elected coverage level.

Employees earning $30,001 and over annually will pay the base rate, plus a fixed percentage of their base annual earnings, as indicated in the column next to the base rate column to the left.

HDHP MEDICAL/Rx COVERAGE (Select Coverage Level or Waive Benefit)

COVERAGE LEVEL	**STEP ONE TO CALCULATE CONTRIBUTION AMOUNT** ANTHEM BCBS HDHP	
	MONTHLY BASE RATE FOR THOSE EARNING $30,000 AND BELOW ANNUALLY	FIXED RATE FOR THOSE EARNING $30,001 AND OVER ANNUALLY
☐ EMPLOYEE ONLY	$60.00	$60 + 1%
☐ EMPLOYEE + 1	$160.00	$160 + 1.5%
☐ FAMILY (EMP + 2 OR MORE)	$200.00	$200 + 2%
☐ DECLINE MEDICAL BENEFITS	**STEP TWO TO CALCULATE CONTRIBUTION AMOUNT** Multiply by 1.16	

Employees earning $30,000 and below annually will pay monthly base rates of $60, $160 or $200 per month, based on elected coverage level.

Employees earning $30,001 and over annually will pay the base rate, plus a fixed percentage of their base annual earnings, as indicated in the column next to the base rate column to the left.

DENTAL COVERAGE (Select Coverage Level or Waive Benefit)

COVERAGE LEVEL	DELTA DENTAL PPO PLAN
	MONTHLY PREMIUM
☐ EMPLOYEE ONLY	$10.00
☐ EMPLOYEE + 1	$25.00
☐ FAMILY (EMP + 2 OR MORE)	$25.00

☐ DECLINE DENTAL BENEFITS

VOLUNTARY VISION COVERAGE (Select Coverage Level or Waive Benefit)

COVERAGE LEVEL	BLUE VIEW VISION PLAN
	MONTHLY PREMIUM
☐ EMPLOYEE ONLY	$7.00
☐ EMPLOYEE + 1	$13.65
☐ FAMILY (EMP + 2 OR MORE)	$20.30

☐ DECLINE VOLUNTARY VISION BENEFITS

HEALTH CARE FLEXIBLE SPENDING ACCOUNT & DEPENEDENT CARE REIMBURSEMENT ACCOUNT

To elect a Flexible Spending Account (FSA) or DC Reimbursement Account, please indicate below the **annual amount** that you would like to contribute to your account (NOTE: this annual amount will be divided among the number of pay periods remaining in the calendar year)

☐ **YES**, I would like to elect a **Health Care Flexible Spending Account**. (**Annual Election Amount Maximum - $2,700 per account**) HCFSA is designated to reimburse expenses for medical, pharmacy, dental or vision expenses paid through deductibles, copays, coinsurance for you and your eligible dependents. **Annual contribution amount $.**

☐ **YES**, I would like to elect a **Dependent Care Reimbursement Account**. (**Annual Election Amount Maximum - $5,000 per household**) DCRA is designed to reimburse expenses incurred to care for your eligible dependents who are incapable of self-care, and is NOT for medical expenses such as deductible or coinsurance. Examples of eligible expenses are daycare, after school care, day camp or preschool for dependents up until the age of 13 or for elder care. **Annual contribution amount $_____.**

Please note:
SMP will allow up to $500 of unused amounts remaining at the end of a plan year in a HCFSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year.

Any employee with a 2018 HCFSA that enrolls in the Health Savings Account for 2019 instead of the HCFSA will waive the right to the $500 carryover.

HEALTH SAVINGS ACCOUNT

To elect a Health Savings Account, please indicate below the **annual amount** that you would like to contribute to your account (NOTE: this annual amount will be divided among the number of pay periods remaining in the calendar year).

☐ **YES**, I have selected the HDHP and would like to elect a **Health Savings Account**. (**Annual Election Amount Maximum - $3,500 per individual and $7,000 per family**) A Health Savings Account is designed to reimburse expenses for medical, pharmacy, dental or vision expenses paid through deductibles and coinsurance for you and your eligible dependents. However, unlike the FSA/DCRA, funds rollover and accumulate year to year to assist with retirement savings. **Annual contribution amount $.**

HEALTH SAVINGS ACCOUNT CATCH-UP PROVISION

Employees over the age of 55 can contribute an additional $1,000 into the HSA

☐ **YES**, I have selected the HDHP, am over the age of 55 and would like to elect a **Health Savings Account** with the catch-up provision. (**Annual Election Amount Maximum - $4,500 per individual and $8,000 per family) Annual contribution amount.**

Please note:
Both Active and COBRA employees are eligible to participate in the HSA. However, please note that employees enrolled in any type of Medicare are NOT eligible. In addition, employees who have other non-qualifying coverage (those with a second health plan, Employee or Spouse enrolled in a traditional Health FSA or HRA) are also ineligible to participate in the HSA.

AUTHORIZATION

I have been provided with information relating to each of the above insurance options. I have reviewed this information and have understood it. I authorize Standard Motor Products to reduce my salary by the agreed upon amounts indicated on this form to pay premiums for myself and/or my dependents on a pre-tax basis for the Medical/Prescription, Dental, Vision and Flexible Spending Account/Reimbursement Account 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, (examples of which include marriage, adoption/birth of a child, divorce, death of a dependent, termination of spouse's employment, etc.) unless my employer changes plan options offered. I understand that I must report any change in family status that may impact my insurance coverage to the Human Resources Department within 31 days of the event.

Print Name _____ **Date** _____

Signature _____