Benefits Election Form (Hourly Employees)
Plan Year: January 1, 2026 through December 31, 2026

Employee Last Name:	Employee First Name:	Employee ID:
Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed	**Gender:** ❒M ❒F	**Date of Birth:**
Full Address, City, State, and Zip code:		**SSN:** -- --
Date of Hire:	**Phone #:**	**Effective Date:**

Please elect or waive coverage for each plan. Western Valley Meat Company contributes toward the medical coverage. The amounts illustrated below account for the employer contribution and will be deducted from your paycheck on a **Bi-Weekly** basis.

☐ **OPT TO WAIVE:** ☐ **Medical** **Reason for waiving: ______________________________________**
☐ **Dental** ☐ **Vision** ☐ **Voluntary Life/AD&D**

☐ **ELECTION TO PARTICIPATE**: I hereby elect to participate in the Western Valley Meat Company Benefits Program. I wish to receive the benefits designated by the checkmarks in the boxes on this form and authorize the corresponding deductions from my wages each pay period.

PLAN CHOICES	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
❒ **Personify/Anthem – Base PPO $6,350 Ded.**	❒$55.00	❒$225.00	❒$150.00	❒$345.00
❒ **Personify/Anthem – Buy-up PPO $0 Ded.**	❒$150.00	❒$450.00	❒$320.00	❒$535.00
❒ **Delta Dental - Dental PPO (DPPO)**	❒$14.00	❒$29.00	❒$42.00	❒$56.00
❒ **VSP - Vision**	❒$6.00	❒$6.00	❒$6.00	❒$6.00
✓ **The Standard – Life/AD&D Insurance**	√$ 0	N/A	N/A	N/A
❒**The Standard – Voluntary Life/AD&D**	❒ Employee: $________	❒ Spouse: $_________	❒ Child(ren): ________	

Dependent Information

Name	Relationship	Date of Birth	Gender	Social Security #	Check Coverage:
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________

Benefits Election Form (Hourly Employees)
Plan Year: January 1, 2026 through December 31, 2026

Dependent Information (continued)					
Name	**Relationship**	**Date of Birth**	**Gender**	**Social Security #**	**Check Coverage**:
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $________

Life/AD&D Primary Beneficiaries: Circle one or Both, if applicable (Basic Life/AD&D; Voluntary Life/AD&D)

Name	**Relationship**	**Date of Birth (if known)**	**Social Security # (if known)**	**Phone #**	**Percentage**

Life/AD&D Contingent Beneficiaries:

Name	**Relationship**	**Date of Birth (if known)**	**Social Security # (if known)**	**Phone #**	**Percentage**

Are you or any enrolling dependents covered under any other insurance? ❒Yes ❒No
If yes, name of Insurance: ______________________________name of covered individuals: ______________________________
Effective Date:____________________ Type of Policy:____________________________ Policy Holder_________________________

I acknowledge that I have received the Employee Benefits Open Enrollment Guide. I understand this sheet does not bind my decision. I must also complete the appropriate enrollment process by the specified deadline.

Employee Signature: ____

Date: ___________________________

If you have any questions regarding the Benefits Program and/or this form, please contact the Western Valley Meat Company Human Resources Department at (559) 218-0384