



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

Employee Last Name:	Employee First Name:	Employee ID:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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
<input type="checkbox"/> Personify/Anthem – Base PPO \$6,350 Ded.	<input type="checkbox"/> \$55.00	<input type="checkbox"/> \$225.00	<input type="checkbox"/> \$150.00	<input type="checkbox"/> \$345.00
<input type="checkbox"/> Personify/Anthem – Buy-up PPO \$0 Ded.	<input type="checkbox"/> \$80.00	<input type="checkbox"/> \$180.00	<input type="checkbox"/> \$135.00	<input type="checkbox"/> \$230.00
<input type="checkbox"/> Delta Dental - Dental PPO (DPPO)	<input type="checkbox"/> \$14.00	<input type="checkbox"/> \$29.00	<input type="checkbox"/> \$42.00	<input type="checkbox"/> \$56.00
<input type="checkbox"/> VSP - Vision	<input type="checkbox"/> \$6.00	<input type="checkbox"/> \$6.00	<input type="checkbox"/> \$6.00	<input type="checkbox"/> \$6.00
<input checked="" type="checkbox"/> The Standard – Life/AD&D Insurance	✓\$ 0	N/A	N/A	N/A
<input type="checkbox"/> The Standard – Voluntary Life/AD&D	<input type="checkbox"/> Employee: \$ _____	<input type="checkbox"/> Spouse: \$ _____	<input type="checkbox"/> Child(ren): _____	
<input type="checkbox"/> The Standard – LTD (for a Select Class)	<input type="checkbox"/> ✓\$ 0	N/A	N/A	

Dependent Information

Name	Relationship	Date of Birth	Gender	Social Security #	Check Coverage:
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____



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Dependent Information (continued)

Name	Relationship	Date of Birth	Gender	Social Security #	Check Coverage:
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> 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