USE INK ONLY

CAJUN INDUSTRIES, LLC

GROUP INSURANCE ENROLLMENT FORM

Health, Dental, Vision, Short-Term Disability & Voluntary Term Life Plans

EMPLOYEE PERSONAL INFORMATION

Last _____ First _____ MI ____ SSN _____ Occupation/Craft _____

Date of Birth ____ / ____ / ____ Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Separated, Divorced

Mailing Address (Include City/State/Zip) _____

Date Hired Full Time ____ / ____ / ____ Tel # (____) _____ Personal Email (REQUIRED) _____

MEDICAL & PHARMACY PLAN

☐ WAIVER: I do NOT want Health coverage because (explain): _____

I understand that Cajun's health plan meets the minimum value standard and is intended to be affordable, and that the Affordable Care Act requires individuals to have health insurance or be subject to a penalty. I understand that by waiving health coverage for myself (and any dependents), my next opportunity to enroll will be at Cajun's next Open Enrollment period unless I have a qualifying event, as described in the enrollment guide.

Employee Signature_____ Print Name_____ Date _____

*If you want Health coverage, please choose an option under either PLAN I or PLAN II below (Check only 1 box).
See page 20 for HSA and FSA "Cafeteria Plan" enrollment.

PLAN I (Traditional Plan)

Level of Coverage	Premium
Employee Only	☐ $54.00 / Week
Employee + One Dependent	☐ $111.00 / Week
Employee + Family	☐ $153.00 / Week

PLAN II (High Deductible Plan)

Level of Coverage	Premium
Employee Only	☐ $21.00 / Week
Employee + One Dependent	☐ $62.00 / Week
Employee + Family	☐ $88.00 / Week

Both plans include $10,000 in Group Basic Life and AD&D insurance. Please designate your beneficiary:

First_____ MI___ Last_____ Relationship _____

VOLUNTARY DENTAL PLAN

Level of Coverage	Premium	
Employee Only	☐ $5.41 / Week	☐ Do Not Want Dental
Employee + Family	☐ $12.97 / Week	

VOLUNTARY VISION PLAN

Level of Coverage	Premium	
Employee Only	☐ $1.41 / Week	☐ Do Not Want Vision
Employee + One	☐ $2.70 / Week	
Employee + Family	☐ $4.59 / Week	

ELIGIBLE DEPENDENT INFORMATION

Complete if you elected Health, Dental and/or Vision benefits for your spouse or children

Relationship	First & Last Name	Enroll Dependent In	Date of Birth	SSN	Sex
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F
		☐ Health ☐ Dental ☐ Vision			☐ M or ☐ F

Do you or your dependents currently have other health insurance? ☐ Yes ☐ No
If yes, give name of policyholder, policy #, name of insured, insurance company, effective date, and if applicable, termination date.

AGREEMENT

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and hereby authorize my employer to deduct from my earnings the required contributions. All contributions will be deducted on a pre-tax basis, except for short-term disability and term life premiums.

_____ _____

Employee Signature Date

Send Forms to: benefits@cajunusa.com OR by Mail: PO Box 104, Baton Rouge, LA 70821, ATTN: Benefits Dept. OR by Fax: 225.756.2124

SPOUSAL COVERAGE AFFIDAVIT

All employees enrolling a spouse in Cajun's health insurance plan must verify their spouses' eligibility under the plan. A spouse is not an eligible dependent if the spouse is currently employed and his or her employer offers health insurance.

If your spouse is currently on Cajun's Health Insurance Plan and is no longer eligible due to eligibility of coverage under his or her employer's health insurance plan, your spouse should notify his or her Human Resources department to inform them that they will be losing their coverage under the Cajun Health Insurance Plan. This qualifies as a "Life Event" and gives them the opportunity to enroll in their employer's plan regardless of the open enrollment period as long as they enroll within 30 days of losing their coverage. Cajun will furnish you with a notice for your spouse's employer upon receipt of this affidavit.

This form must be returned to the Benefits Department with your enrollment to ensure that your spouse is eligible to be covered by the health insurance plan.

VERIFICATION OF SPOUSE ELIGIBILITY

*Please complete the following questions:

1. Is your spouse employed either full-time or part-time?
Full Time ☐ Part Time ☐ Not Employed ☐

2. If employed, does your spouse's employer offer medical benefits to their employees?
Yes ☐ No ☐ N/A ☐

*If not offered medical benefits, you must notify the Benefits Department if your spouse becomes eligible for insurance coverage due to his or her employment status change.

I hereby certify that I understand that if my spouse has medical coverage available to them through their own employer, they are not eligible to be covered as a dependent on the Cajun Health Insurance Plan.

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge.

I understand that any misrepresentation or falsification of information I have provided above will permit the Cajun Health Insurance Plan to terminate the spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. I further understand that I must report any changes in my spouse's employment status to the Benefit's Department.

In addition, willful provision of false information may result in disciplinary action up to and including termination of employment.

_____	_____
Employee Printed Name	Social Security # of Employee
_____	_____
Employee Signature	Date Signed

VOLUNTARY SHORT TERM DISABILITY - EMPLOYEE ONLY (Choose One)

☐ Do Not Want Short-Term Disability ☐ Yes I Want Short-Term Disability. Weekly cost is the amount of weekly benefit divided by 10 * $0.14

VOLUNTARY TERM LIFE INSURANCE (Choose One)

NOTE: You must elect at least as much insurance on yourself in order to elect insurance for a spouse or child.

Employee Benefit Election (Volume of Life Insurance): ☐ Do Not Want Voluntary Term Life Insurance

☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000

☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000

Spouse Benefit Election (Include Spouse Info Below if Elected):	Child Benefit Election: (Include Child Info Below if Elected):
☐ $10,000 ☐ $25,000 ☐ $50,000	☐ $10,000

BENEFICIARY DESIGNATION FOR VOLUNTARY TERM LIFE

I hereby direct payment of any death benefit under the Plan to the beneficiary listed below. Unless otherwise provided, if more than one beneficiary is designated in any one class, each beneficiary in the same class shall share equally.

Name	Percentage	Relationship
Address	Type: ☐ Primary OR ☐ Contingent	SSN
Name	**Percentage**	**Relationship**
Address	Type: ☐ Primary OR ☐ Contingent	SSN
Name	**Percentage**	**Relationship**
Address	Type: ☐ Primary OR ☐ Contingent	SSN
Name	**Percentage**	**Relationship**
Address	Type: ☐ Primary OR ☐ Contingent	SSN

ELIGIBLE DEPENDENT INFORMATION

Complete if you elected Voluntary Term Life benefits for your spouse or children

Spouse's Name	Birth Date	☐ M or ☐ F	SSN
Name(s) of Child(ren)	Birth Date	☐ M or ☐ F	SSN
	Birth Date	☐ M or ☐ F	SSN
	Birth Date	☐ M or ☐ F	SSN
	Birth Date	☐ M or ☐ F	SSN
	Birth Date	☐ M or ☐ F	SSN

AGREEMENT

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and hereby authorize my employer to deduct from my earnings the required contributions. Short-term disability and voluntary term life contributions will be deducted on a post-tax basis. I understand that voluntary term life coverage is portable and convertible. Portability must be applied for within 60 days of losing coverage, and conversion must be applied for within 31 days of losing coverage by visiting www.Principal.com/Cajun or calling 800-986-3343.

Employee Printed Name _____ Social Security # of Employee _____ Date _____

Employee Signature _____ Email Address (REQUIRED) _____

PARTICIPATION AGREEMENT FOR HEALTH SAVINGS ACCOUNTS/HSA &
FLEXIBLE SPENDING ACCOUNTS/FSA "CAFETERIA PLAN"

Note: Participation in these accounts is VOLUNTARY. You may skip this page if you do not want to enroll in an HSA or FSA account.

IRS Publication 502 provides a full listing of eligible medical expenses at https://www.irs.gov/pub/irs-pdf/p502.pdf.

☐ **Cafeteria Plan / Healthcare Flexible Spending Account (FSA) Agreement**

*The (PRE-TAX) contribution amount you choose is only to be used to reimburse eligible expenses, up to $2,700.
Your FSA election will expire at the end of this calendar year, it will not roll over. A new election must be made each year.

I ELECT TO CONTRIBUTE $_____ PER PAY PERIOD, which is $ _____ PER PLAN YEAR

If you would like a second debit card for your spouse/dependent, please provide their full name: _____

☐ **Dependent Daycare Reimbursement Account Agreement**

*The(PRE-TAX) contribution amount you choose is only to be used to fund eligible dependent care expenses.
If single, the maximum amount is $5,000. If married, the maximum per calendar year is the lesser of: (1) $5,000 for married filing joint or $2,500 for married filing separate; (2) your spouse's total annual compensation, or (3) ½ of your total annual compensation.

I ELECT TO CONTRIBUTE $_____ PER PAY PERIOD, which is $ _____ PER PLAN YEAR

☐ **Health Savings Account (HSA) Contributions (must be enrolled in a High Deductible Health Plan)**

*The (PRE-TAX) contribution amount you choose is only to be used to fund eligible expenses.
Health Savings Account maximum is $3,500 for Employee Only plan/$7,000 for Employee + 1 and Family plans.

I ELECT TO CONTRIBUTE $_____ PER PAY PERIOD, which is $ _____ PER PLAN YEAR

☐ **Limited Health Flexible Spending Account (must be enrolled in a High Deductible Health Plan)**

*The (PRE-TAX) contribution amount you choose may only be used to reimburse ***dental, vision and preventative care*** expenses.
Limited Use FSA maximum is $2,700 per year.

I ELECT TO CONTRIBUTE $_____ PER PAY PERIOD, which is $ _____ PER PLAN YEAR

PLEASE READ CAREFULLY

HEALTH CARE FLEXIBLE SPENDING DEBIT CARD AGREEMENT: By signing and using the *TakeCare Benefits* card I agree to the terms of the Funds Transfer Disclosure Statement ("Agreement") received with the card. Use of the card is authorized for qualified healthcare expenses only as outlined in my Plan Documents. I certify that expenses will not be reimbursed under any other health plan coverage. Upon request, I will immediately submit any other documentation requested by the OMNI Group, the Plan Administrator. Failure to submit such documentation may result in: (1) my obligation to repay the amount to my employer; (2) immediate suspension or revocation of the Card, and/or (3) taxable, payroll deductions by my employer of the ineligible expenses.

PARTICIPATION / WAIVER: My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may not change my annual election except in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description. If I voluntarily waive coverage under Option IV, I understand the benefits of participating in the plan and that if I should later desire to participate I will have to wait until the next Plan Year unless I experience an official change in family status.

_____ _____
EMPLOYEE PRINTED NAME DATE SIGNED:

_____ _____
EMPLOYEE SIGNATURE SOCIAL SECURITY # OF EMPLOYEE