# NI BENEFIT ELECTION/CHANGE FORM

## EMPLOYEE DATA

| SOCIAL SECURITY # (Last 4 Digits Only) | EMPLOYEE NAME (Last, First, M.I.) |
|---|---|
| | |

## TRANSACTION / MIDYEAR CHANGES

**DATE OF CHANGE** _____ (Proof May Be Required)

**REASON:**

☐ NEW ENROLLEE ☐ DIVORCE ☐ CHANGE IN DEPENDENT STATUS
☐ BIRTH/ADOPTION OF CHILD ☐ DEATH ☐ OPEN ENROLLMENT
☐ MARRIAGE ☐ CHANGE IN DEPENDENT'S EMPLOYMENT OR BENEFITS ☐ HSA CONTRIBUTION (NO PROOF NEEDED)

**DAY CARE FSA ONLY:**

☐ CHANGE IN DEPENDENT CARE PROVIDER/RATE

**ALL CHANGES MUST BE MADE WITHIN 31 DAYS FROM THE DATE OF THE QUALIFYING EVENT**

## MEDICAL COVERAGE SELECTION

**HEALTH** (Includes Medical and Rx)

☐ **CIGNA HIGH DEDUCTIBLE HEALTH PLAN**

☐ **CIGNA PREMIUM HEALTH**

☐ **CIGNA PREMIUM HEALTH PLUS**

☐ **KAISER HMO (CA Only)**

☐ EMPLOYEE ONLY ☐ EMPLOYEE + CHILDREN
☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + FAMILY

☐ WAIVE

**HEALTH SAVINGS ACCOUNT WITH HDHP ONLY**

☐ EMPLOYEE ONLY $_____ (Annual Contribution)
MAX EMPLOYEE CONTRIBUTION $2,550 NI TO CONTRIBUTE $900 (Prorated)

☐ EMPLOYEE+DEPENDENT(S) $_____ (Annual Contribution)
MAX EMPLOYEE CONTRIBUTION $5,100 NI TO CONTRIBUTE $1,800 (Prorated)

☐ WAIVE

**DO YOU WISH TO APPLY FOR SPOUSE COVERAGE?**
☐ **YES** ☐ **NO**

**IF "NO"**
- ☐ I HAVE NO SPOUSE
- ☐ SPOUSE HAS OTHER INSURANCE
- ☐ MY SPOUSE IS AN NI EMPLOYEE

**IF "YES,"** IS YOUR SPOUSE ELIGIBLE FOR MEDICAL COVERAGE UNDER ANY OTHER GROUP MEDICAL PLANS?

☐ **YES** ☐ **NO**

**IF YES,** THEN SELECT FROM THE FOLLOWING CHOICES
- ☐ I AGREE TO PAY THE MONTHLY "SPOUSE ADDITION" PREMIUM. (Cover My Spouse Under The NI Plan With NI As Primary Coverage.)
- ☐ MY SPOUSE WILL HAVE PRIMARY COVERAGE UNDER ANOTHER PLAN. (The NI Plan Will Be Secondary Coverage.)

**IF NO,** THEN SELECT FROM THE FOLLOWING CHOICES:
- ☐ MY SPOUSE IS NOT EMPLOYED
- ☐ MY SPOUSE IS EMPLOYED BY_____

EMPLOYER TEL. #_____

**COMPLETE THE DEPENDENT INFORMATION SECTION ON PAGE 2**

## ADDITIONAL BENEFITS

**VISION**

☐ EMPLOYEE ONLY ☐ EMPLOYEE + CHILDREN
☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + FAMILY

☐ WAIVE

**DENTAL**

☐ **METLIFE DENTAL** ☐ **METLIFE DENTAL PLUS**

☐ EMPLOYEE ONLY ☐ EMPLOYEE + CHILDREN
☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + FAMILY

☐ WAIVE

**FLEXIBLE SPENDING ACCOUNT** ($100 Min / $2,650 Max)

☐ REGULAR FSA $_____ (PH AND PHP PLANS ONLY)
☐ LIMITED USE FSA $_____ (Dental + Vision Expenses HDHP Plan Only)

☐ WAIVE

**COMMUTER BENEFIT** ($260 Max / Per Month)

☐ ENROLL AMOUNT $_____

☐ WAIVE

**DAY CARE FLEXIBLE SPENDING ACCOUNT**

☐ $_____ (Household Max $5000)

☐ WAIVE

**IDENTITY THEFT PROTECTION**

☐ **LIFELOCK BENEFIT ELITE** ☐ **LIFELOCK ULTIMATE PLUS**

☐ EMPLOYEE ONLY ☐ EMPLOYEE + CHILDREN
☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + FAMILY

☐ WAIVE

**VOLUNTARY LIFE INSURANCE**

**EMPLOYEE ADDITIONAL**
☐ 1X SALARY (Up To $200,000)
☐ 2X SALARY (Up To $200,000)
☐ 3X SALARY (Up To $200,000)

**DEPENDENT**
SPOUSE'S SS#_____
☐ SPOUSE ($30,000) ☐ CHILD(REN) ($10,000)

☐ WAIVE

**GROUP LEGAL**

☐ ENROLL ☐ WAIVE

## ADD/DROP INFORMATION

| MEDICAL (Add/Drop) | DENTAL (Add/Drop) | FULL NAME (Last, First) | DEPENDENT SS# | MALE/FEMALE | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|---|---|---|---|
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## BENEFICIARY INFORMATION

**BENEFICIARY BASIC LIFE AD&A** (Additional Life if Elected. All percentages combined must equal 100%)

☐ **PRIMARY**

NAME:_____ RELATIONSHIP_____ DOB:_____ PERCENTAGE:_____

NAME:_____ RELATIONSHIP_____ DOB:_____ PERCENTAGE:_____

☐ **SECONDARY** (OPTIONAL)

NAME:_____ RELATIONSHIP_____ DOB:_____ PERCENTAGE:_____

NAME:_____ RELATIONSHIP_____ DOB:_____ PERCENTAGE:_____

## AUTHORIZATION and ACKNOWLEDGMENTS

By signing this form (either electronically or in writing) I am applying for, and authorizing payroll deductions for, the marked coverages and reimbursement accounts. I understand that my voluntary selection of National Instruments Medical Coverage, if any, also constitutes an election to participate in the associated National Instruments Wellness Program, and I authorize any legally permissible surcharges under that program. I acknowledge that I have received, understand, and agree to abide by the terms and conditions of the applicable coverages and reimbursement accounts I have elected, including any eligibility requirements. I understand that I cannot change or suspend any election I have made with regard to medical coverage (excluding any health savings account contribution amount), dental coverage, or flexible spending account coverage until the next plan year unless my family status changes. I cannot transfer money between flexible spending accounts, and any money in a flexible spending account not used during the plan year for qualified expenses will be forfeited. I acknowledge that any unsubstantiated Flexible Spending Account debit card expense I make will be taxable to me the following year. Any misrepresentation of information will be handled consistent with our NI guidelines. If I elect NI medical coverage for my spouse and my spouse is or becomes eligible for medical benefits under a medical benefits plan offered by my spouse's employer at any time during the plan year for which this application applies, I hereby authorize any increase in payroll deductions to account for the applicable 'spouse addition' premium.

DATE:_____ EMPLOYEE SIGNATURE:_____ ENTERED_____