

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 _____

REASON (Proof May Be Required):

- | | | |
|--|---|---|
| <input type="checkbox"/> NEW ENROLLEE | <input type="checkbox"/> DIVORCE | <input type="checkbox"/> CHANGE IN DEPENDENT STATUS |
| <input type="checkbox"/> BIRTH/ADOPTION OF CHILD | <input type="checkbox"/> DEATH | <input type="checkbox"/> OPEN ENROLLMENT |
| <input type="checkbox"/> MARRIAGE | <input type="checkbox"/> CHANGE IN DEPENDENT'S EMPLOYMENT OR BENEFITS | <input type="checkbox"/> 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)

- | | |
|--|--|
| <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE + CHILDREN |
| <input type="checkbox"/> EMPLOYEE + SPOUSE | <input type="checkbox"/> EMPLOYEE + FAMILY |

☐ WAIVE

HEALTH SAVINGS ACCOUNT WITH HDHP ONLY

- ☐ EMPLOYEE ONLY \$ _____ (Annual Contribution)
MAX EMPLOYEE CONTRIBUTION \$2,750 NI TO CONTRIBUTE \$750 (Prorated)
- ☐ EMPLOYEE+DEPENDENT(S) \$ _____ (Annual Contribution)
MAX EMPLOYEE CONTRIBUTION \$5,500 NI TO CONTRIBUTE \$1,500 (Prorated)
- ☐ EMPLOYEES 55+ CAN CONTRIBUTE AN EXTRA \$1,000 (Catch up Contribution)

☐ 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 THROUGH VSP

- | | |
|--|--|
| <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE + CHILDREN |
| <input type="checkbox"/> EMPLOYEE + SPOUSE | <input type="checkbox"/> EMPLOYEE + FAMILY |

☐ WAIVE

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

- | | |
|--|--|
| <input type="checkbox"/> REGULAR FSA \$ _____
(PH AND PHP PLANS ONLY) | <input type="checkbox"/> LIMITED USE FSA \$ _____
(DENTAL + VISION EXPENSES HDHP PLAN ONLY) |
|--|--|

☐ WAIVE

DAY CARE FLEXIBLE SPENDING ACCOUNT

☐ \$ _____ (Household Max \$5000)

☐ WAIVE

ADDITIONAL LIFE INSURANCE

EMPLOYEE ADDITIONAL

- ☐ 1X SALARY (Up To \$300,000)
☐ 2X SALARY (Up To \$300,000)
☐ 3X SALARY (Up To \$300,000)

DEPENDENT

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

☐ WAIVE

DENTAL

☐ METLIFE DENTAL PLUS ☐ METLIFE DENTAL PLUS

- | | |
|--|--|
| <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE + CHILDREN |
| <input type="checkbox"/> EMPLOYEE + SPOUSE | <input type="checkbox"/> EMPLOYEE + FAMIL |

☐ WAIVE

COMMUTER BENEFIT (\$260 Max / Per Month)

☐ ENROLL AMOUNT \$ _____

☐ WAIVE

IDENTITY THEFT PROTECTION

INFOARMOR

- | | |
|--|--|
| <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE + DEPENDENT(S) |
|--|--|

☐ WAIVE

GROUP LEGAL

☐ ENROLL

☐ WAIVE

ADD/DROP INFORMATION

MEDICAL (Add/Drop)	DENTAL (Add/Drop)	VISION (Add/Drop)	IDENTITY THEFT	FULL NAME (LAST, FIRST)	DEPENDENT SS#	MALE/ FEMALE	DATE OF BIRTH	RELATIONSHIP

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 _____