BROTHER'S, INC. & BROTHER'S SECURITY PLUS, INC.

MEDICAL & DENTAL INSURANCE ENROLLMENT WORKSHEET – NEW JERSEY & DELAWARE
FEBRUARY 1, 2015 - JANUARY 31, 2016

Name:		Social Security No.:	
Date of Hire:		Employee Number:	
Eligibility Date:		Insurance:	

Please note: These figures do not reflect any "Years of Service" (YOS) discounts.
Figures reflect weekly per-pay deductions.

COVERAGE SELECTIONS

	MEDICAL PLANS				DENTAL- DELTA
COVERAGE	**HDHP**	**POS-4B**	**POS-3B**	**PPO**	**PPO**
Employee Only	☐ $ 29.34	☐ $52.68	☐ $64.52	☐ $88.87	☐ $6.08
Employee & Spouse	☐ $ 129.98	☐ $157.25	☐ $183.81	☐ $240.71	☐ $24.45
Employee & Child	☐ $ 129.98	☐ $147.66	☐ $166.85	☐ $222.34	☐ $24.45
Employee & Children	☐ $ 196.67	☐ $226.15	☐ $253.89	☐ $325.86	☐ $24.45
Family	☐ $ 196.67	☐ $238.37	☐ $275.50	☐ $349.91	☐ $24.45

_____ I am declining medical insurance coverage at this time. I have other insurance coverage: Yes / No
_____ I am declining dental insurance coverage at this time. I have other insurance coverage: Yes / No
_____ This is a state or federal program. Yes / No

Primary Policy Holder's Name: _____ Relationship to Employee: _____

COVERAGE CONDITIONS

In signing this form, I am stating that I understand and agree to the following:

All payroll deductions elected in this form constitute a salary reduction agreement between Brother's Inc. and me for the Plan Year February 1, 2015 through January 31, 2016. I cannot change or revoke this salary reduction election at any time during the plan year unless I have a change in family status (e.g. marriage, divorce, death of a spouse or child, birth or adoption of a child or termination of employment of a spouse). Prior to the first day of each plan year, I will be offered the opportunity to participate in the plan or to change my salary reduction for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected the same plan and status as indicated in this election.

Brother's Inc. may reduce or cancel the amount of my salary reduction or otherwise modify this agreement, if it is believed advisable in order to satisfy certain provisions of the internal revenue code. The reduction in my salary under this agreement will be in addition to any reductions under other agreements or benefit plans. I understand that if I elect to participate in the Plan, it is possible that my Social Security Benefit may be slightly reduced. This salary reduction agreement will automatically terminate in the event the plan is terminated or discontinued. I understand that in the event my employment terminates prior to the end of the month, I will be responsible for my premium contribution to the end of that month through an increased payroll deduction from my final paycheck.

This agreement is subject to the terms of **BROTHER'S INC.'S PREMIUM ONLY PLAN** as amended from time to time, and shall be governed by Pennsylvania law and revokes any prior election and compensation reduction agreement relating to the **BROTHER'S INC. PREMIUM ONLY PLAN.**

_____ _____
Signature Date

FOR OFFICE USE ONLY – YEARS OF SERVICE DISCOUNT

Basic Medical & RX Weekly Deduction:		Discounted Medical & RX Weekly Deduction:	
Basic Dental Weekly Deduction:		Discounted Dental Weekly Deduction:	
Total Basic Weekly Deduction:		Total Discounted Weekly Deduction:	

BROTHER'S, INC. & BROTHER'S SECURITY PLUS, INC.

MEDICAL & DENTAL INSURANCE ENROLLMENT WORKSHEET - PENNSYLVANIA
FEBRUARY 1, 2015 - JANUARY 31, 2016

Name:		Social Security No.:	
Date of Hire:		Employee Number:	
Eligibility Date:		Insurance:	Keystone

Please note: These figures do not reflect any "Years of Service" YOS discounts.
Figures reflect weekly per-pay deductions.

COVERAGE SELECTIONS

	MEDICAL PLANS				DENTAL- DELTA
COVERAGE	**HDHP**	**POS-4B**	**POS-3B**	**PPO**	**DMO OR PPO - PA**
					(Check Box and Circle One)
Employee Only	☐ $ 29.34	☐ $52.68	☐ $64.52	☐ $88.87	☐ $3.45 - $6.08
Employee & Spouse	☐ $ 129.98	☐ $157.25	☐ $183.81	☐ $240.71	☐ $8.17 - $24.45
Employee & Child	☐ $ 129.98	☐ $147.66	☐ $166.85	☐ $222.34	☐ $8.17 - $24.45
Employee & Children	☐ $ 196.67	☐ $226.15	☐ $253.89	☐ $325.86	☐ $8.17 - $24.45
Family	☐ $ 196.67	☐ $238.37	☐ $275.50	☐ $349.91	☐ $8.17 - $24.45

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Primary Policy Holder's Name: _____ Relationship to Employee: _____

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_____ _____
Signature Date

FOR OFFICE USE ONLY – YEARS OF SERVICE DISCOUNT

Basic Medical & RX Weekly Deduction:		Discounted Medical & RX Weekly Deduction:	
Basic Dental Weekly Deduction:		Discounted Dental Weekly Deduction:	
Total Basic Weekly Deduction:		Total Discounted Weekly Deduction:	