



Windsor HR Services, Inc., is proud to announce Open Enrollment for the 2019 plan year. If your company has elected to participate in the Windsor 401(k) plan (including the new ROTH option), you may also enroll effective the first day of the new quarter (Jan. 1, 2019).

Please note *Windsor HR Services'* open enrollment is **not applicable** to your company's major medical health plan. Open enrollment for health insurance will vary from company to company depending upon the renewal date of the policy. During this open enrollment you will have the opportunity to make changes, enroll, or switch to different plans offered by Windsor HR Services, Inc.

Windsor HR Services has restructured the benefits programs to meet the requirements of the Affordable Care Act.

As part of the open enrollment, all employees will be required to sign the **Flex Benefits Authorization Form** as required by the IRS. Even if you elect not to participate in the benefits program, you must still sign a Flex Benefits Authorization Form and initial that you decline and have been offered the benefits.

Please review the Open Enrollment information carefully and submit your elections before the designated due date. Absolutely no changes or new enrollments will be accepted after the cutoff date without a qualifying event as defined by IRS and ERISA regulations. Please contact your HR Representative for information regarding qualifying events.

As always, the Staff and Management of Windsor HR Services are proud to serve you!

Sincerely,

Daron Lancaster

Daron Lancaster, President



2019 Employee Benefits Election Form

Employee Name: (please print) _____ Effective Date: _____

To Employees: Please fill out an election form completely even if you are waiving coverage. Check the appropriate boxes for the benefits listed below.

Step 1: Choose your elections

Table with 3 columns: Network, PLAN 1 - HDHP - HSA, PLAN 2 - HDHP - HSA. Rows include Calendar Year Deductible, Coinsurance, Out-of-Pocket Max, Office Visit, Preventive Care, Emergency Room, Hospital Services, and Prescriptions.

Medical Coverage - Check one coverage type: _____

I am currently enrolled in On Trac's Medical plan and I desire to maintain my current elections with NO changes:

Table with 4 columns: Coverage Type, Cost, Waiver Box, Reason. Rows include Employee Only, Employee + Spouse, Employee + Child(ren), and Family.

I am waiving medical: _____ Reason: _____

Table with 2 columns: BCBS DENTAL, Deductible, Maximum Annual Benefit, Diagnostic & Preventive Service, Basic Services, Major Services, Orthodontics, Waiting Periods.

Dental Coverage - Check one coverage type: _____

I am currently enrolled in On Trac's Dental plan and I desire to maintain my current elections with NO changes:

Table with 4 columns: Coverage Type, Cost, Waiver Box, Reason. Rows include Employee Only, Employee + Spouse, Employee + Child(ren), and Family.

I am waiving dental: _____ Reason: _____

Table with 2 columns: BCBS VISION, Deductible, Exam (every 12 months), Materials, Lenses, Frames, Contact Lenses (in lieu of glasses).

Vision Coverage - Check one coverage type: _____

I am currently enrolled in On Trac's Vision plan and I desire to maintain my current elections with NO changes:

Table with 4 columns: Coverage Type, Cost, Waiver Box, Reason. Rows include Employee Only, Employee + Spouse, Employee + Child(ren), and Family.

I am waiving vision: _____ Reason: _____

Step 2: Indicate/Update your beneficiary below

BCBS Group Life Insurance

The company sponsors a \$25,000 group term life insurance (under age 65) policy for all employees enrolled in the medical. Please update your beneficiary below.

Beneficiary Name: _____ Percentage: _____ Relationship: _____

Step 3: Fill in your personal information and designate your dependents

EMPLOYEE: Last Name, First Name, MI, Address, State, Zip, Date of Hire, Date of Birth, Phone Number, Social Security Number, Gender (Male/Female)

SPOUSE: Last Name, First Name, MI, Social Security Number, Date of Birth, Gender (Male/Female)

CHILD 1: Last Name, First Name, MI, Social Security Number, Date of Birth, Gender (Male/Female)

CHILD 2: Last Name, First Name, MI, Social Security Number, Date of Birth, Gender (Male/Female)

CHILD 3: Last Name, First Name, MI, Social Security Number, Date of Birth, Gender (Male/Female)

(To add more dependents, please attach another sheet of paper with the above information for each dependent)

Step 4: Confirmation of Benefit Elections and/or Waivers

By signing below, I understand the medical coverage I have elected and/or waived above is effective January 1st, 2019, and will remain effective until December 31, 2019 unless I have a qualifying event. If I do experience a life event change, I further acknowledge that I have 30 days in order to notify Human Resources of this change.

Signature: _____ Today's Date: _____



Windsor HR Services Christmas Club 2019 Employee Payroll Deduction Authorization Form

Ask yourself the question. *Do you get more than a little stressed about cash during and after the Christmas season?* Who wants to worry about December's credit card bills over New Years? Why not avoid all of that stress and plan ahead with Windsor's Christmas Savings Club?

- **Earn 2% APY on your savings**

Make sure you can pay your Christmas bills. Plan ahead with Windsor HR Services and have all of your Christmas funds set aside by Thanksgiving. In fact, you'll receive a better interest rate than a regular bank account! Why not collect interest on your money before Christmas instead of paying interest after?

As a Windsor Christmas Savings Club member, you'll earn 2% APY on the money you set aside from each paycheck during the year.

Here is how it works:

Select an amount you would like deducted from your paycheck and your money will be placed into an account that will earn 2% APY. All deductions will end after **November 1, 2019**, and your money will be sent to you the week of Thanksgiving (earned interest is included at payout, and is considered taxable).

I, _____, hereby authorize Windsor HR Services, Inc., and their subsidiaries, agents or assigns, to make the deductions approved below, on my behalf, into the Windsor Christmas Savings Club 2019 Fund.

I authorize \$ _____ (amount in dollars only) per pay period. **Note all new employees hired after August 31, 2019, may not enter the Christmas Club until next Open Enrollment**

I understand that should my employment with _____ / Windsor HR Services, Inc., cease at any time I will be entitled to all monies that I have contributed to the Windsor Christmas Club Fund account upon separation from the company. I further understand if deductions are stopped and my balance withdrawn prior to the 2019 disbursement, all earned interest will be forfeited, and I may not reenter the Club until the next scheduled Open Enrollment. Interest will not accrue on early withdrawals. Interest for 2019 is 2% APY.

I DECLINE TO PARTICIPATE IN THE 2019 CHRISTMAS CLUB.

Signature: _____ Printed Name: _____

Date: _____



Group/Voluntary Life Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE

WINDSOR HR SERVICES #:126417

Form with fields: EMPLOYEE NAME, EMPLOYER/LOCATION NAME, EMPLOYEE ADDRESS, SOCIAL SECURITY NUMBER, DATE OF BIRTH, SEX, DATE OF EMPLOYMENT, HOURS WORKED PER WEEK, OCCUPATION, ANNUAL EARNINGS, SPOUSE'S DATE OF BIRTH

PROVIDED BY WINDSOR HR SERVICES, INC:

GROUP LIFE/AD&D: EMPLOYEE ONLY \$25,000 FLAT (BASE LIFE/AD&D INSURED BY LINCOLN FINANCIAL GROUP)

PLEASE INDICATE YOUR VOLUNTARY LIFE COVERAGE ELECTION BELOW:

VOLUNTARY LIFE: EMPLOYEE ONLY \$10,000 \$20,000 \$100,000 \$150,000 OTHER DECLINE

NOTE: If you have chosen coverage over the Guarantee Issue amount of \$150,000, you will also need to complete an Evidence of Insurability form...

Beneficiary Information

Designate your beneficiary(ies) below.

Table with 3 columns: NAME OF BENEFICIARY, RELATION TO YOU, BENEFIT %. Includes a row for 'IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:'

REQUEST FOR SIGNATURE Please read the back of this form carefully before signing below.

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request...

Employee Signature

Date

Work Phone

Home Phone

LIMITATIONS AND EXCLUSIONS

DELAYED EFFECTIVE DATE

Employee:

Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

EXCLUSION FOR SUICIDE

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

AD&D BENEFIT EXCLUSIONS

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime under state or federal law;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Operating any motorized vehicle while intoxicated. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.)

UNUM CORPORATION LIFESTYLE LIFE
Windsor HR Services, Inc.
Monthly Payroll Deduction

EMPLOYEE PREMIUM

Age Band	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$70,000	\$100,000	\$130,000	\$150,000
0-24	\$0.69	\$1.38	\$2.07	\$2.76	\$3.45	\$4.83	\$6.90	\$8.97	\$10.35
25-29	\$0.79	\$1.58	\$2.37	\$3.16	\$3.95	\$5.53	\$7.90	\$10.27	\$11.85
30-34	\$0.98	\$1.96	\$2.94	\$3.92	\$4.90	\$6.86	\$9.80	\$12.74	\$14.70
35-39	\$1.39	\$2.78	\$4.17	\$5.56	\$6.95	\$9.73	\$13.90	\$18.07	\$20.85
40-44	\$1.99	\$3.98	\$5.97	\$7.96	\$9.95	\$13.93	\$19.90	\$25.87	\$29.85
45-49	\$3.17	\$6.34	\$9.51	\$12.68	\$15.85	\$22.19	\$31.70	\$41.21	\$47.55
50-54	\$5.04	\$10.08	\$15.12	\$20.16	\$25.20	\$35.28	\$50.40	\$65.52	\$75.60
55-59	\$7.75	\$15.50	\$23.25	\$31.00	\$38.75	\$54.25	\$77.50	\$100.75	\$116.25
60-64	\$12.10	\$24.20	\$36.30	\$48.40	\$60.50	\$84.70	\$121.00	\$157.30	\$181.50
65-69	\$21.00	\$42.00	\$63.00	\$84.00	\$105.00	\$147.00	\$210.00	\$273.00	\$315.00
70-74	\$37.48	\$74.96	\$112.44	\$149.92	\$187.40	\$262.36	\$374.80	\$487.24	\$562.20
75+	\$73.44	\$146.88	\$220.32	\$293.76	\$367.20	\$514.08	\$734.40	\$954.72	\$1,101.60

150,000 IS THE MAXIMUM THAT MAY BE ISSUED WITHOUT ANSWERING HEALTH QUESTIONS

*Age = Current Year – Birth Year.



**2019 Flex Benefits
Authorization Enrollment Form**

Employee Name: _____ SS#: _____ - _____ - _____

Client/Worksite Name: _____

The options provided under this plan must be made available to all Windsor HR Services Full Time employees. Please check all plans that you want to participate in on a pre-tax basis. Your elections will remain in effect throughout the benefit year 2019. After making your selections, please sign and date the form. **If you do not wish to participate in any of the plan options, please check the Waiver of Benefits section and sign below as required by the IRS. Each year you may carry over \$500 of unused medical expenses forward to the next calendar year.**

INSURANCE PREMIUM CONVERSION

I elect to have Windsor HR Services deduct my contributions/premiums to the following group and/or supplemental benefits plans on a pretax basis. *I also acknowledge that enrollment in any of the employee benefits plans below, if available, requires that I complete a separate insurance company enrollment application form, and in some cases, be approved for coverage by the insurance company.*

___ Group Health/Life ___ Cancer Insurance ___ Vision Insurance

___ Supplemental Life (Max. \$50,000 pretax) ___ Accident Insurance ___ Group Dental

___ Un-reimbursed Medical Expenses Total to be deducted per year \$ _____
(Maximum Authorized \$2,650)

___ Child/Dependent Day Care Expenses Total to be deducted per year \$ _____

WAIVER OF PRE-TAXED BENEFITS UNDER THE FLEXIBLE PLAN

___ **I elect to waive all pre-tax benefits under the Flexible Benefits Plan, but understand that I may elect certain benefits on an after-tax basis. Except for a Qualifying Event/Change in Status, I understand that I cannot elect pre-tax benefits until the next anniversary date.**

This election to participate in (or waive participation in) the Windsor HR Services Flex Benefits Plan will continue until amended or revoked. I cannot change or revoke this Election before next open enrollment, unless I experience a Qualifying Event/ Change in Status (e.g., marriage, divorce, death of a spouse, birth or adoption of a child, or termination or commencement of employment of a spouse).

Employee's Signature: _____ Date: ____/____/____



**E-Mail Election or
Opt-Out Form**

In an effort to improve communications and service to the employees of our client companies, Windsor HR Services, Inc. has established *The Voice of Windsor* e-news program. We will begin sending this quarterly newsletter directly to you as well as other announcements such as new benefit programs, open enrollment forms, etc. upon your electing to enroll in this program.

Your personal identity is protected under federal law, and we pledge to you that your e-mail address will never be sold or given to outside vendors. To enroll in the e-news program please complete this form and return it to your HR Service Representative. If you choose not to enroll, please complete the opt-out section.

*If you have previously enrolled or opted out, you do not have to complete another form.
Thank You!*

Employee Name: _____ Date: _____
(Please Print)

Client Company: _____

E-mail address: _____

Confirm e-mail address: _____

Employee Signature: _____

Opt-out

I understand the e-news program and elect to opt-out at this time. I further understand that I will not be able to enroll in the program until the next open enrollment.

Employee Name: _____ Date: _____
(Please Print)

Client Company: _____

Employee Signature: _____