2025 Bolin Enterprises, LLC Group Eligibility Form

Please complete the following form for your 2025 benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Bolin Enterprises and are therefore waiving all coverage, please check the appropriate box for waiving coverage in each section.

☐ Open Enrollment	☐ New Hire	☐ Qualifying Event	Effective Date:
	Termination ☐	Reason: _____ Date of event: _____	/ /

Company Name	**Bolin Enterprises, Inc. Group**	Employee Number	
Employee First Name		Middle Initial	Employee Last Name
Employee Home Address		SSN	
City, State, Zip		Date of Hire	
Employee Phone Number		Date of Birth	
Marital Status		Gender	Male / Female

Medical-Weekly		**Carrier: BlueCross BlueShield**
HDHP/HSA (A)		
Employee Only	☐ $52.00	Bolin will be making a contribution of $1,300 into your HSA on your behalf to help you pay towards any qualified medical expenses you may incur through the year. You too can put your own pre-tax dollars, the IRS annual allowable maximum for employee only is $4,300 and for family is $8,550. (Employee Only: $82.70 weekly , Family: $164.43 weekly)
Employee + Spouse*	☐ $183.00	
Employee + Child(ren)*	☐ $152.00	
Family*	☐ $291.00	
Employee HSA contribution Amount[2]		
☐ I am choosing to waive medical coverage for myself and my dependents.		

Medical-Weekly	
Base Plan PPO (B)	
Employee Only	☐ $52.00
Employee + Spouse*	☐ $202.00
Employee + Child(ren)*	☐ $167.00
Family*	☐ $328.00
☐ I am choosing to waive medical coverage for myself and my dependents.	

NOTE: Employees active on our health insurance plan that do not participate in the wellness program will be responsible for an additional 10% of their individual premium.

Dental–Weekly			**Carrier: BlueCross BlueShield**
Low Plan PPO		**High Plan PPO**	
Employee Only	☐ $4.22	Employee Only	☐ $5.93
Employee + Spouse*	☐ $8.78	Employee + Spouse*	☐ $12.03
Employee + Child(ren)*	☐ $10.88	Employee + Child(ren)*	☐ $16.35
Family*	☐ $16.20	Family*	☐ $23.80
☐ I am choosing to waive dental coverage for myself and my dependents.			

* If any election other than employee only is selected please complete dependent information

Vision–Weekly	Carrier: BlueCross BlueShield
Vision Plan	
Employee Only	☐ $1.75
Employee + Spouse*	☐ $3.33
Employee + Child(ren)*	☐ $3.51
Family*	☐ $5.16
☐ I am choosing to waive vision coverage for myself and my dependents.	

Voluntary Life & ADD — **Carrier: BlueCross BlueShield**

☐ I choose to elect Voluntary Term Life/AD&D coverage for myself and/or my dependents (spouse and/or child(ren)). I understand that I will be responsible for paying the full cost of the premium for this coverage if approved. I also understand that I must complete another form to process this coverage request, and that the requested coverage is subject to carrier approval

☐ I choose to continue with the same voluntary term life coverage as enrolled in 2024

☐ I choose to increase my voluntary term life coverage from 2024 to this amount:_____

I understand that I will be responsible for paying the full cost of the premium for this coverage if approved. I also understand that I must complete another form to process this coverage request, and that the requested coverage is subject to carrier approval

☐ I choose to decrease my voluntary term life coverage from 2024 to this amount:_____

☐ I am choosing to waive Voluntary Term Life/AD&D coverage for myself and/or my dependent (spouse and or child(ren).

Dependent Information

Name	Date of Birth	Social Security Number	Gender	Relationship	Medical	Dental	Vision

2025 Changes

	YES	NO
Is the address that you supplied on the front a new address?		
Is the phone number that you supplied on the front a new phone number?		
Did you have a marital status change in 2024?		
Do you need to change your life insurance beneficiary information? (See HR for new form)		
Did you have any dependents born in 2024? (If YES, please make sure to provide name, birthdate and gender above with any other dependents so that HR can update their database)		

Authorization and Signature

Every employee is required to complete this form in its entirety, either electing group benefit coverage or waiving group benefit coverage. By signing this form you are authorizing pre-tax deduction under the cafeteria plan, your next opportunity to make changes will be during the next open enrollment period unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth of a child or adoption of a child. Please contact your Human Resources representative if you experience a qualifying life event within 30 days of the life event.

Print Name	Signature	Date

* If any election other than employee only is selected please complete dependent information