Otsuka

BENEFITS ENROLLMENT FORM
OPFA

1. EMPLOYEE INFORMATION

Name (please print):		Social Security #:
Address:	Date of Birth (MM/DD/YYYY):	Date of Hire:
City:	State:	ZIP:
Phone Number:	Email Address:	

2. MEDICAL PLAN SELECTION

Please check (✓) one box
Medical Coverage includes Prescription Drug Coverage

	Anthem PPO	Anthem HSA
Employee	☐	☐
Employee + Spouse/Domestic Partner	☐	☐
Employee + Child(ren)	☐	☐
Family	☐	☐

☐ **Waive Medical Coverage**

3. HEALTH SAVINGS ACCOUNT (HSA)

Please check (✓) one box

If you elect to participate in the Anthem HSA plan, you may contribute funds to an HSA on a pre-tax basis. The annual HSA contribution maximums are **$4,500 for Employee Only coverage** and **$9,000 for all other coverage levels** inclusive of company contributions as well. If you are age 55 or older, you may contribute an additional $1,000 (regardless of the coverage level you elected).

OPFA will contribute an annual amount of **$800 for an individual or $1,600 for an employee and 1 or more dependents** toward the HSA. Employee contributions are made on a per-pay basis and will be prorated based on when you enroll.

If you are interested in participating in the HSA, please check the box below, and choose your HSA plan and list your annual and per-pay contribution amounts.

☐ **Yes,** I would like to participate in the HSA. **Annual Contribution:** $_____ **OR Per Pay Period Contribution:** $_____

☐ **No,** I do not wish to participate in the HSA.

4. SPENDING ACCOUNTS

Healthcare Flexible Spending Account (FSA)
Maximum: $3,500

Annual Contribution: $_____

Dependent Care Flexible Spending Account (DCFSA)
Maximum: $7,500 / $3,750 if married, filing separately

Annual Contribution: $_____

Limited Purpose Flexible Spending Account (LPFSA)
Maximum: $3,500

Annual Contribution: $_____

☐ **No,** I do not wish to participate in the Spending Accounts.

* *Choose the Healthcare FSA if enrolling in the PPO medical plan, or if you are not enrolling in a medical plan, but still wish to participate in an FSA.*

** *LPFSA works with the HDHP medical plan to cover dental and vision expenses.*

*** *For 2027, any employee with a base salary of at least $165k will be considered a Highly-Compensated Employee and be limited to an annual DCFSA contribution of $4,000.*

5. DENTAL PLAN SELECTION

Please check (✓) one box

	Delta Dental PPO
Employee	☐
Employee + Spouse/Domestic Partner	☐
Employee + Child(ren)	☐
Family	☐
☐ **Waive Dental Coverage**	

6. VISION PLAN SELECTION

Please check (✓) one box

	VSP Vision Plan
Employee	☐
Employee + Spouse/Domestic Partner	☐
Employee + Child(ren)	☐
Family	☐
☐ **Waive Vision Coverage**	

7. DEPENDENT ENROLLMENT INFORMATION

Dependent First & Last Name	Gender (M/F)	Relationship (Spouse, DP, Child)	Date of Birth (MM/DD/YYYY)	Social Security # (required)	Select Plan(s) to Add/Cancel
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision

8. METLIFE LEGAL PLAN (MONTHLY)

Please check (✓) one box

☐ **Yes,** I wish to elect the MetLife Legal Plan **$16.50 Monthly via payroll deduction**
Family coverage included at no additional cost including spouse and dependents.

☐ **No,** I do not wish to participate in the MetLife Legal Plan.

9. NORTON ID THEFT (MONTHLY)

Please check (✓) one box

Employee	☐ $9.49
Employee + Family	☐ $17.98

☐ **No,** I do not wish to participate in the Norton Life Lock Plan.

10. THE STANDARD WHOLE LIFE WITH LONG-TERM CARE

Please check (✓) one box

Employee Only

☐ **Yes,** I wish to elect The Standard Whole Life with Long-Term Care coverage.

Requested Face Amount (up to $200,000):

$_____

☐ **No,** I do not wish to elect The Standard Whole Life with Long-Term Care coverage.

Spouse/ Domestic Partner

☐ **Yes,** I wish to elect The Standard Whole Life with Long-Term Care coverage.

Requested Face Amount (up to $30,000):

$_____

☐ **No,** I do not wish to elect The Standard Whole Life with Long-Term Care coverage.

11. INSURANCE COVERAGE - LIFE/AD&D, SHORT-TERM DISABILITY (STD), LONG-TERM DISABILITY (LTD)

OPFA pays 100% of premiums for Life and Accidental Death and Dismemberment (AD&D) Insurance, Short-Term and Long-Term Disability Insurances.

- OPFA provides 2x your base annual earnings to a maximum of $1,500,000 of Basic Life/ 5x your base annual earnings to a maximum of $1,500,000 AD&D coverage to all benefits eligible employees.
- Short-Term Disability (STD) replaces 60% of average weekly wages (up to $3,000) to employees up to 26 weeks.
- Long-Term Disability (LTD) replaces 60% of monthly pre-disability earnings (up to $15,000) to employees who are disabled beyond 180 days.

* *Please see Rates and premiums on separate rate sheet.*

12. VOLUNTARY LIFE INSURANCE – EMPLOYEE

Please check (✓) one box

Employees have the option of purchasing additional Life coverage through Lincoln Financial Group. You may purchase coverage in increments of $10,000 up to a maximum of 6x Annual Earnings or $1,500,000. **The Guarantee Issue amount is $250,000.**

☐ **Yes,** I wish to elect Employee Voluntary Life Coverage. **Election Amount:** $_____

☐ **No,** I do not wish to elect Employee Voluntary Life.

NOTE: You **must** elect Voluntary Employee Life to participate in the following Voluntary Spouse and Child(ren) Life Plans. Employee is responsible for 100% of the premium.

* *Evidence of Insurability (EOI) is required for coverage beyond $20,000 up to the Guaranteed Issue amount (GI).*

* *Please see Rates and premiums on separate rate sheet.*

13. VOLUNTARY LIFE INSURANCE – SPOUSE

Please check (✓) one box

You may purchase Spousal coverage in increments of $5,000 up to a maximum of $250,000. **The Guarantee Issue amount is $50,000.**

☐ **Yes,** I wish to elect Spousal Voluntary Life Coverage.

Election Amount: $_____

☐ **No,** I do not wish to elect Spousal Voluntary Life.

* *Evidence of Insurability (EOI) is required for coverage beyond $20,000 up to the Guaranteed Issue amount (GI).*

14. VOLUNTARY LIFE INSURANCE – CHILD(REN)

Please check (✓) one box

You may purchase Child coverage in increments of $2,500 up to a maximum of $20,000.

☐ **Yes,** I wish to elect Child(ren) Voluntary Life Coverage.

Election Amount: $_____

☐ **No,** I do not wish to elect Child(ren) Voluntary Life.

* *Please see Rates and premiums on separate rate sheet.*

Please indicate your beneficiary designation for your Life Insurance benefits in the event of your death. You may indicate a Primary and Contingent Beneficiary. You may also name more than one Primary and/or Contingent Beneficiary. Unless designated otherwise, payment will be made in equal shares or all to the survivor. You have the right to change this beneficiary designation at any time. If you would like to designate different beneficiaries on each insurance plan, please notify Human Resources.

15. BENEFICIARY INFORMATION

Beneficiary Name (please print):		Beneficiary Type: ☐ Primary ☐ Contingent
Beneficiary Address:	Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):
Phone Number:	Email Address:	
Relationship:	% of Benefit:	

Beneficiary Name (please print):		Beneficiary Type: ☐ Primary ☐ Contingent
Beneficiary Address:	Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):
Phone Number:	Email Address:	
Relationship:	% of Benefit:	

Beneficiary Name (please print):		Beneficiary Type: ☐ Primary ☐ Contingent
Beneficiary Address:	Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):
Phone Number:	Email Address:	
Relationship:	% of Benefit:	

16. VOLUNTARY CRITICAL ILLNESS INSURANCE – EMPLOYEE

Please check (✓) one box

Employees have the option of purchasing Critical Illness coverage through Lincoln Financial. Coverage is available in the following tiers: $10,000, $20,000, $30,000, and $40,000.

☐ **Yes,** I wish to elect Employee Critical Illness Coverage.

Election Amount: $_____

☐ **No,** I do not wish to elect Employee Critical Illness Coverage.

17. VOLUNTARY CRITICAL ILLNESS INSURANCE – SPOUSE

Please check (✓) one box

Employees have the option of purchasing Critical Illness coverage through Lincoln Financial for their Spouse. Coverage is available in the following tiers: $10,000, $20,000, $30,000, and $40,000.

☐ **Yes,** I wish to elect Spousal Critical Illness Coverage.

Election Amount: $_____

☐ **No,** I do not wish to elect Spousal Critical Illness Coverage.

CRITICAL ILLNESS INSURANCE RATES—MONTHLY RATES PER $10,000 OF EE COVERAGE

AGE	EMPLOYEE (OR EMPLOYEE CHILDREN)		SPOUSE RATES (PER $5,000)		EMPLOYEE + SPOUSE (OR EMPLOYEE + FAMILY)	
	NON-TOBACCO	TOBACCO	NON-TOBACCO	TOBACCO	NON-TOBACCO	TOBACCO
<25	$3.39	$3.71	$1.95	$2.15	$5.34	$5.86
25-29	$3.51	$4.04	$2.05	$2.34	$5.56	$6.38
30-34	$4.02	$4.93	$2.34	$2.87	$6.36	$7.80
35-39	$4.84	$6.71	$2.79	$3.88	$7.63	$10.59
40-44	$5.71	$8.52	$3.26	$4.82	$8.97	$13.34
45-49	$7.25	$11.90	$4.20	$6.87	$11.45	$18.77
50-54	$9.57	$16.11	$5.76	$9.54	$15.33	$25.65
55-59	$12.64	$21.49	$7.43	$12.44	$20.07	$33.93
60-64	$15.58	$25.99	$9.17	$15.10	$24.75	$41.09
65-69	$19.07	$30.28	$11.25	$17.77	$30.32	$48.05
70+	$26.23	$40.37	$15.70	$23.70	$41.93	$64.07

18. VOLUNTARY ACCIDENT INSURANCE (MONTHLY RATES)

Please check (✓) one box

	Lincoln Financial Voluntary Accident Plan Monthly Rates
Employee	☐ $7.05
Employee + Spouse/Domestic Partner	☐ $12.76
Employee + Child(ren)	☐ $16.85
Family	☐ $22.56

☐ **Waive Voluntary Accident Insurance**

19. VOLUNTARY HOSPITAL INDEMNITY INSURANCE (MONTHLY RATES)

Please check (✓) one box

	Lincoln Financial Voluntary Hospital Indemnity Monthly Rates
Employee	☐ $11.63
Employee + Spouse/Domestic Partner	☐ $26.92
Employee + Child(ren)	☐ $22.21
Family	☐ $36.95

☐ **Waive Voluntary Hospital Indemnity Insurance**

EMPLOYEE AUTHORIZATION

I hereby acknowledge that I cannot change my elections during the plan year, unless there is a qualified change in status under the terms of the plan. I understand that if I am waiving coverage now, I am eligible to enroll in group coverage through OPFA during the open enrollment period each year and during the year within 30 days of a qualified change in status.

Additionally, due to the timing of enrollment, the bi-weekly premiums due for your benefit elections may not be reflected in your first paycheck. In this case, I acknowledge that the missed deductions will automatically be applied to my next paycheck.

Employee Signature: _____ **Date:** _____

If you have any questions about your benefits, please contact Grace Miller (GMiller@otsuka-america.com).