# 2017 STEIN MART BENEFITS ENROLLMENT / CHANGE FORM

Full-time Weekly-paid Associates – Eligible for benefits on the first day of the month following 60-days of full-time employment
Full-time Semi-monthly-paid and Weekly-Paid Management Associates – Eligible for benefits on the first day of full-time employment

**Forms must be submitted to HR within 31-days of the Effective Date**
Benefit deductions begin on the first check of the month of eligibility.

**First Name:** **MI:** **Last Name:** **Soc. Sec. #:** **Store #:**

**Address:** **City:** **State:** **Zip:** **Date of Birth:** **Email address:**

☐ **Single** ☐ **Married** | ☐ **Male** ☐ **Female** | **Position:** | **FT Hire Date:** **Insurance Effective Date:**

**Type of Enrollment:**
☐ New FT Employee
☐ New PT to FT Employee
☐ Special Enrollment – Please check reason and give date
☐ Marriage ☐ Birth or Adoption of Child ☐ Divorce ☐ Loss of other coverage ☐ Other
Date of the event: Other event:

**Medical Coverage:**
☐ I elect the Emerald Plan
☐ I elect the CHIP Plan
☐ I elect the CHIP Light Plan
☐ Associate Only
☐ Associate + Child(ren)
☐ Associate + Spouse
☐ Family (Associate + Spouse + Child(ren)
☐ I do not want medical coverage*

**Dental Coverage:**
☐ I elect the Red Plan
☐ I elect the Blue Plan
☐ Single Coverage
☐ Family Coverage
☐ I do not want dental coverage*

**Vision Coverage:**
☐ I elect vision coverage
☐ Single Coverage
☐ Family Coverage
☐ I do not want vision coverage*

**FLEXIBLE SPENDING ACCOUNT -** Select one or both accounts and an annual deduction amount for ***each selection.***

***For HR Use Only:***

☐ Health Care Account Annual Deduction Amount _____________ (min of $120 and max of $2500/annually) _________________ per pay period

☐ Dependent Care Account Annual Deduction Amount ____________ (min of $120 and max of $5000/annually if tax filing is single or married /jointly, max of $2500 if married filing separately) _________________ per pay period

List eligible dependents to be covered. A valid social security number must be provided for all dependents, and a copy of the legal marriage certificate must be provided when adding a spouse.

| Dependent Name | Social Security Number | Date of Birth | Relationship | Coverage ☐ Add ☐ Delete |
|---|---|---|---|---|
| | | | | ☐ Medical ☐ Dental ☐ Vision |
| | | | | ☐ Medical ☐ Dental ☐ Vision |
| | | | | ☐ Medical ☐ Dental ☐ Vision |

**LIFE INSURANCE**
Beneficiary: Soc Sec #: Address: Relationship to you:

**SHORT AND LONG TERM DISABILITY INSURANCE (<u>for weekly paid associates only</u>):**

Weekly Paid Associates - can only elect Benefit A**:** ☐ Benefit A: STD/LTD Disability Insurance (STD $150/week, LTD 60% of base pay up to $600/mo) $3.33 per pay period

Weekly Merch/Dept Mgrs and Corp weekly associates (can elect Benefit A or Benefit B): ☐ Benefit B: STD/LTD Disability Insurance (STD $300/week, LTD 60% of base pay up to $1,200/mo) $6.66 per pay period

☐ I do not elect Disability Insurance benefits - I understand I will not be permitted to enroll until the next Open Enrollment Period, and I will be asked to submit Evidence of Insurability (EOI) at my own expense at that time.

* I understand the choice(s) indicated above must remain in effect for the entire plan year unless I have a change in family status(such as birth or adoption of a child, marriage, divorce, death of a spouse or dependent, or a spouse's change of employment, dependent no longer eligible, or initial eligibility for Medicare). An Enrollment Form and proof of the qualifying event must be provided to HR within 31-days of the date of the Family Status Change (including newborns).

**CERTIFICATION OF FORM:** I HEREBY AUTHORIZE PAYROLL DEDUCTIONS FOR ANY ELECTIONS ON THIS FORM TO BE MADE BY MY EMPLOYER. I STATE ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE

ASSOCIATE SIGNATURE: ________________________________________________________________ DATE: _________________________