2026 Benefits Enrollment Worksheet

You must either **ENROLL** or **WAIVE** coverage. Please refer to the rate sheet for prices on all products. The SISCO call center is available for questions during your enrollment. Contact SISCO at (844) 631-6104.

Reason for Application

☐ New Group Plan ☐ Life Event / Date: ☐ Status Change: ☐ Dependent Add / Delete	☐ Change Name / Address ☐ Part Time to Full Time ☐ New Hire ☐ Annual Open Enrollment	☐ Late Enrollee ☐ Termination ☐ Waiving Coverage ☐ Other

Your Personal Information

First Name:	**Last Name:**	**Date of Hire:**
SSN:	**Primary Phone:**	**Date of Birth:**
E-mail:	**Address:**	**City, State, Zip:**

Has any adult (19 and older) person to be insured used tobacco in the last 12 months? Yes ☐ No ☐

Dependent Information

Enter dependent information for all dependents who will be covered on your insurance plans.

Name	Relationship	Gender	SSN	Date of Birth	Disabled Y/N
	☐ Spouse ☐ Child	☐ Female ☐ Male			
	☐ Child	☐ Female ☐ Male			
	☐ Child	☐ Female ☐ Male			
	☐ Child	☐ Female ☐ Male			

Medical Plan Options

Select your medical plan from the following options. Check the box on the right based on the plan and coverage category. Check "waive" if you are waiving medical coverage.

Medical Plan(s)	Coverage Category	Election	Dep Name / Relation
MEC Basic	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
MEC Plus	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
MVP	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Major Medical Buy Up	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Medical Indemnity Plan 1	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Medical Indemnity Plan 2	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Medical Indemnity Plan 3	Employee Only	☐	----------
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Waive Medical Coverage		☐	
Waive Medical Indemnity Plan Coverage		☐	

Recuro

Check the "add" or "waive" box at the bottom of the chart to add or decline coverage.

	If you are currently enrolled in one of our medical plans
When will Recuro be available?	The benefit will automatically be available.
Copay per televisit	MVP Plan Participants: $45 copay / televisit MEC Plus Plan Participants: $0 copay / televisit
Weekly cost for employees	No charge (Included in your medical plan)
Add Teladoc Benefit	☐
Waive Teladoc Benefit	☐

Voluntary Dental Plan

Check the box on the right based on the coverage category. Check "waive" if you are waiving voluntary dental coverage.

Voluntary Dental Plan	Coverage Category	Election	Dep Name / Relation
Dental Plan High	Employee Only	☐	
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Waive Voluntary Dental Coverage		☐	

Voluntary Dental Plan	Coverage Category	Election	Dep Name / Relation
Dental Plan Low	Employee Only	☐	
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Waive Voluntary Dental Coverage		☐	

Voluntary Vision Plan

Check the box on the right based on the coverage category. Check "waive" if you are waiving voluntary vision coverage.

Voluntary Vision Plan	Coverage Category	Election	Dep Name / Relation
Vision Plan	Employee Only	☐	
	Employee + Spouse	☐	
	Employee + Child(ren)	☐	
	Employee + Family	☐	
Waive Voluntary Vision Coverage		☐	

Voluntary Life

Check the box on the right based on the coverage category. Check "waive" if you are waiving voluntary life coverage.

Voluntary Life Plan(s)	Coverage Category	Election	Dep Name / Relation
Voluntary Life	Employee Only	☐	–
	Employee + 1 Dependent	☐	
	Employee + Family	☐	
Waive Voluntary Life Coverage		☐	

Your Beneficiaries

Provide primary and secondary (if applicable) beneficiary information for life insurance. Beneficiary percentage must equal 100%.

First Name	Last Name	Address	Relationship	Type (Primary / Secondary)

Secondary Beneficiary (if applicable)

First Name	Last Name	Address	Relationship	Type (Primary / Secondary)

Short Term Disability (STD)

Check the appropriate box on the right if you want to accept or waive short-term disability coverage.

STD Coverage	Election
STD $650 Monthly Benefit	☐
Waive Short-Term Disability	☐

Voluntary Critical Illness and Accident

Check the box on the right based on the coverage category. See weekly age-based rates. Check "waive" if you are waiving voluntary coverage.

Critical Illness Plan	Coverage Category	Election
Critical Illness	Employee Only	☐
	Employee + Spouse	☐
	Employee + Child(ren)	☐
	Employee + Family	☐
Waive Voluntary Critical Illness		☐

Accident Plan	Coverage Category	Election
Accident	Employee Only	☐
	Employee + Spouse	☐
	Employee + Child(ren)	☐
	Employee + Family	☐
Waive Voluntary Accident		☐

I have reviewed the benefits offered and made my desired coverage selections (or waived coverage where applicable). I understand that the stated elections for my Medical, Dental, and Vision plans will be administered on a pre-tax basis under Section 125 and that these elections are irrevocable until the next enrollment period or in the event of a Qualified Life Event.

Employee Printed Name _____ **Employee Signature** _____ **Date** _____