ACEMCO INCORPORATED

2018 Benefit Election Form

Name:_____ Date of Hire:_____ Effective Date:_____

I elect the following and understand my deduction per pay will be as shown:

(Benefits are effective 90 days following date of hire.)

Priority Health

Option 1: Value Plan 2000/4000, RX 10/30/50

____	Employee Only	$33.12
____	Employee + 1	$79.49
____	Family	$93.60

Option 2: Value Plan 4000/8000, RX 10/30/50

____	Employee Only	$24.37
____	Employee + 1	$58.50
____	Family	$69.20

Option 3: Value Plan 5000/10,000, RX 10/30/50

____	Employee Only	$21.21
____	Employee + 1	$50.91
____	Family	$60.26

Ameritas Dental

100/50/50/50, $1000 Max Per Year

____	Employee Only	$4.04
____	Employee + 1	$9.00
____	Family	$14.53

Ameritas Vision

VSP:

____	Employee Only	$1.60
____	Employee + 1	$2.66
____	Family	$4.47

Guardian Cancer Plan

____	Advantage Plan	Rate: ____
____	Premium Plan	Rate: ____

Guardian Voluntary Life

Employee Amount	_____	Rate: _____
Spouse Amount	_____	Rate: _____
Child	$10,000	Rate: _____
Total		Rate: _____

Total Deduction Per Pay: _____

I authorize ACEMCO to deduct the above amount from my pay on a weekly basis. I understand that no changes can be made to my elections until Open Enrollment March 1st unless I experience a qualifying event (birth, adoption, loss of coverage, divorce, loss of Medicare, Medicaid or MiChild).

Signed: _____ Date: _____