



2025 BENEFITS ELECTION FORM

Refer to 2025 Benefits Guide on www.GatesHealth.com for full plan details & premium rates.

Employee information

Employee Name:

Employee ID:

Date of Event:

(date of hire, qualifying life event date)

Reason for Event

I am a new employee/newly eligible

I want to remove dependents

I want to change my HSA contribution

I want to add dependents

I have lost/gained coverage

Medical Coverage

CDHP1
CDHP2
PPO
Decline coverage

Coverage Level

Employee Only
Employee + Spouse
Employee + Children
Family

Health Savings Account

(eligible only for employees on CDHP plans)

Employee
Employee + Dependents
Decline coverage

Coverage Level

Amount: / year

Flexible Spending Accounts

Medical FSA (PPO only)
Limited Purpose FSA (CHDP only)
Dependent Care FSA
Parking FSA (Denver & CSC only)
Decline coverage

Coverage Level

Amount: / monthly
Amount: / monthly
Amount: / monthly
Amount: / monthly

Dental Coverage

High (2)
Low (1)
Decline Coverage

Coverage Level

Employee Only
Employee + Spouse
Employee + Children
Family

Vision Coverage

Decline coverage

Coverage Level

Employee Only
Employee + Spouse
Employee + Children
Family

Identity & Fraud Coverage

Elect Coverage
Decline Coverage

Coverage Level

Employee Only
Employee + Dependents

Legal Coverage

Elect Coverage

Decline Coverage

Accidental Coverage

High
Low
Decline coverage

Coverage Level

Employee Only
Employee + Spouse
Employee + Children
Family

Critical Illness Coverage

High
Low
Decline coverage

Coverage Level

Employee Only
Employee + Spouse
Employee + Children
Family

Hospital Indemnity Coverage

Elect Coverage
Decline coverage

Coverage Level

Employee Only
Employee + Spouse
Employee + Children
Family

Long Term Disability Coverage (Buy Up)

Elect Coverage
Decline coverage

Employee Supplemental Life Coverage

1x Annual Salary
2x Annual Salary
3x Annual Salary
4x Annual Salary
Decline Coverage

Employee Supplemental AD&D Coverage

1x Annual Salary
2x Annual Salary
3x Annual Salary
4x Annual Salary
Decline Coverage

Spousal Supplemental Life Coverage

Elect coverage
Amount:

Decline coverage

Spousal Supplemental AD&D Coverage

Elect coverage
Amount:

Decline coverage

*Must be enrolled in Employee Supplemental Life and AD&D of equal or greater value than spouse to elect this benefit. Evidence of insurability may be required.
Coverage: \$10,000 up to max of \$100,000 - must be in \$10,000 increments

Child Supplemental Life Coverage

\$10,000
\$20,000
\$30,000
Decline coverage

Child Supplemental AD&D Coverage

\$10,000
\$20,000
\$30,000
Decline coverage

*Must be enrolled in Employee Supplemental Life/AD&D of equal or greater amount to elect this benefit.

Dependent Information

Relationship	Legal Name	Gender	Date of Birth	Social Security #

I acknowledge that the selections made above are accurate and reflect my desired benefits.

Date:

Employee Signature