2026 PLAN YEAR
Benefits Enrollment Form
Richmond Facility

Employee Authorization

☐ I authorize Mafco Worldwide, LLC to deduct from my wages, on a pre-tax basis, my contributions for coverage in the amounts set forth below.

Employee Name: _____ Date: _____

Spending Account Elections

Please confirm if you would like to sign up for a Flexible Spending Account (FSA):

☐ Yes (If yes, please see HR to discuss further)

☐ No

Please confirm if you would like to sign up for a Health Savings Account (HSA):

☐ Yes (If yes, please see HR to discuss further)

☐ No

Medical/Rx Election: Weekly Pre-Tax Payroll Deduction

Please check (✓) one box.

Medical Plan Options	Employee	Employee + Spouse	Employee + Child(ren)	Family
HDHP	☐ $11.83	☐ $36.67	☐ $34.31	☐ $45.55
Base Plan	☐ $19.23	☐ $59.61	☐ $55.76	☐ $74.03
Buy-Up Plan	☐ $26.70	☐ $82.77	☐ $77.43	☐ $102.80

☐ **I elect to waive coverage in any medical plan.** Signature: _____ Date: _____

Dental Election: Weekly Pre-Tax Payroll Deduction

Please check (✓) one box.

Dental Plan Options	Employee	Employee + Spouse	Employee + Child(ren)	Family
Low Plan	☐ $3.19	☐ $6.52	☐ $7.67	☐ $11.38
High Plan	☐ $3.56	☐ $7.27	☐ $8.54	☐ $12.69

☐ **I elect to waive coverage in any dental plan.** Signature: _____ Date: _____

Vision Election: Weekly Pre-Tax Payroll Deduction — Please check (✓) one box.

Vision Plan Options	Employee	Employee + Spouse	Employee + Child(ren)	Family
Vision Plan	☐ $1.20	☐ $3.06	☐ $3.06	☐ $3.06

☐ **I elect to waive coverage in the vision plan.** Signature: _____ Date: _____

Voluntary Critical Illness Election – *Refer to rate table*

☐ **I elect Critical Illness coverage for myself in the following monthly amount:**
_____

☐ **I elect Critical Illness coverage for my spouse* in the following monthly amount:**
_____

☐ **I elect Critical Illness coverage for my child* in the following monthly amount:**
_____

☐ **I elect to waive Critical Illness coverage.**
Signature: _____ Date: _____

* Must elect employee coverage in order to elect coverage for spouse or dependent child

Voluntary Critical Illness Monthly Rate per $1,000

Age	EE/Spouse Rate
<25	$0.19
25 - 29	$0.27
30-34	$0.37
35-39	$0.55
40-44	$0.83
45-49	$1.22
50-54	$1.75
55-59	$2.36
60-64	$3.41
65-69	$4.85
70+	$7.99
Child (under 18) - Rate per $7,500	
	$2.78

Voluntary Critical Illness Deduction Calculation Instructions:

Find "Age Band" of individual to be covered in chart (left column) and locate "Monthly Rate Per Age Band" (right column). Multiply desired amount of coverage ($10,000 multiples) by monthly rate to determine deduction amount.

To determine cost of coverage:

[Age band rate] x [multiple of coverage] = [monthly deduction] | *Example:* $50,000 of coverage for a 50–54-year-old employee; 5 x $1.75 = $8.75

Voluntary Accident Election: Monthly Pre-Tax Payroll Deduction — Please check (✓) one box.

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Voluntary Accident	☐ $8.75	☐ $14.33	☐ $15.27	☐ $20.85

☐ **I elect to waive coverage in the Accident plan.** Signature: _____ Date: _____

Voluntary Hospital Indemnity Election: Monthly Payroll Deduction — Please check (✓) one box.

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Voluntary Hospital Indemnity	☐ $11.99	☐ $25.69	☐ $17.77	☐ $31.47

☐ **I elect to waive coverage in the Hospital Indemnity plan.** Signature: _____ Date: _____

Voluntary Life Election – *Refer to rate table*

☐ **I elect Voluntary Life coverage for myself in the following monthly amount:**

_____

☐ **I elect Voluntary Life coverage for my spouse* in the following monthly amount:**

_____

☐ **I elect Voluntary Life coverage for my child* in the following monthly amount:**

_____

☐ **I elect to waive Voluntary Life coverage.**

Signature: _____ Date: _____

* Must elect employee coverage in order to elect coverage for spouse or dependent child

Voluntary Life Monthly Rate per $1,000

Age	EE/Spouse Rate
<20	$0.060
20-24	$0.060
25-29	$0.060
30-34	$0.090
35-39	$0.100
40-44	$0.120
45-49	$0.180
50-54	$0.310
55-59	$0.510
60-64	$0.790
65-69	$1.520
70+	$2.460

Child (under 18) - Rate per $1,000
$0.207

Voluntary Life Deduction Calculation Instructions:

Find "Age Band" of individual to be covered in chart (left column) and locate "Monthly Rate Per Age Band" (right column). Multiply desired amount of coverage (specified multiples) by monthly rate to determine deduction amount.

To determine cost of coverage:

[Age band rate] x [multiple of coverage] = [monthly deduction] | *Example:* $50,000 of coverage for a 50–54-year-old employee; 50 x $0.310 = $15.50

Voluntary AD&D Election – *Refer to rate table*

☐ **I elect Voluntary AD&D coverage for myself in the following monthly amount:**

_____

☐ **I elect Voluntary AD&D coverage for my spouse* in the following monthly amount:**

_____

☐ **I elect Voluntary AD&D coverage for my child* in the following monthly amount:**

_____

☐ **I elect to waive Voluntary AD&D coverage.**

Signature: _____ Date: _____

* Must elect employee coverage in order to elect coverage for spouse or dependent child

Voluntary AD&D Monthly Rate per $1,000

Employee/Spouse/Child Rate
$0.036

Voluntary AD&D Deduction Calculation Instructions:

To determine cost of coverage:

[Age band rate] x [multiple of coverage] = [monthly deduction]

Example: $50,000 of coverage for Spouse or Child; 50 x $0.036 = $1.80

Applicant Statement of Understanding

I hereby declare that the information that I provided on this form is accurate and complete, and if applicable, that the dependents that I am enrolling in coverage or opting out of coverage are my legal dependents and meet the definitions outlined in the plan documents.

Employee Signature: _____ Date: _____