



**Benefits Election Form (Hourly Employees)**  
**January 1, 2026 through December 31, 2026**



<b>Employee Last Name:</b>	<b>Employee First Name:</b>	<b>Employee ID:</b>
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Date of Birth:</b>
<b>Full Address, City, State, and Zip code:</b>		<b>SSN:</b> -- --
<b>Date of Hire:</b>	<b>Phone #:</b>	<b>Effective Date:</b>

Please elect or waive coverage for each plan. CVM/CLW Foods contributes toward the medical coverage. The amounts illustrated below account for the employer contribution and will be deducted from your paycheck on a **Bi-Weekly** basis.

**OPT TO WAIVE:**  **Medical** Reason for waiving: \_\_\_\_\_  
 **Dental**  **Vision**  **Voluntary Life/AD&D**

**I AM ALREADY ENROLLED AND ELECT TO NOT MAKE ANY CHANGES TO MY COVERAGE(S)**

**ELECTION TO PARTICIPATE:** I hereby elect to participate in the CVM/CLW Foods Benefits Program. I wish to receive the benefits designated by the checkmarks in the boxes on this form and authorize the corresponding deductions from my wages each pay period. If I do not sign and return this form, my previous elections will remain intact.

PLAN CHOICES	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="checkbox"/> Personify/Anthem – Base PPO \$6,350 Ded.	<input type="checkbox"/> \$55.00	<input type="checkbox"/> \$225.00	<input type="checkbox"/> \$150.00	<input type="checkbox"/> \$345.00
<input type="checkbox"/> Personify/Anthem – Buy-up PPO \$0 Ded.	<input type="checkbox"/> \$150.00	<input type="checkbox"/> \$450.00	<input type="checkbox"/> \$320.00	<input type="checkbox"/> \$535.00
<input type="checkbox"/> Delta Dental - Dental PPO (DPPO)	<input type="checkbox"/> \$14.29	<input type="checkbox"/> \$29.68	<input type="checkbox"/> \$33.02	<input type="checkbox"/> \$50.65
<input type="checkbox"/> Principal - Vision	<input type="checkbox"/> \$2.74	<input type="checkbox"/> \$5.77	<input type="checkbox"/> \$5.64	<input type="checkbox"/> \$9.24
<input checked="" type="checkbox"/> <b>The Standard – Life/AD&amp;D Insurance</b>	<input checked="" type="checkbox"/> \$ 0	Life Only: <input type="checkbox"/> \$ 0	Life Only: <input type="checkbox"/> \$ 0	Life Only: <input type="checkbox"/> \$ 0
<input type="checkbox"/> <b>The Standard – Voluntary Life/AD&amp;D</b>	<input type="checkbox"/> Employee: \$ _____		<input type="checkbox"/> Spouse: \$ _____	<input type="checkbox"/> Child(ren): _____

**Dependent Information**

Name	Relationship	Date of Birth	Gender	Social Security #	Check Coverage:
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____



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**Dependent Information (continued)**

Name	Relationship	Date of Birth	Gender	Social Security #	Check Coverage:
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life/AD&D Election: \$ _____

**Life/AD&D Primary Beneficiaries: Circle one or Both, if applicable (Basic Life/AD&D; Voluntary Life/AD&D)**

Name	Relationship	Date of Birth (if known)	Social Security # (if known)	Phone #	Percentage

**Life/AD&D Contingent Beneficiaries:**

Name	Relationship	Date of Birth (if known)	Social Security # (if known)	Phone #	Percentage

Are you or any enrolling dependents covered under any other insurance? Yes No

If yes, name of Insurance: \_\_\_\_\_ name of covered individuals: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Type of Policy: \_\_\_\_\_ Policy Holder \_\_\_\_\_

**I acknowledge** that I have received the Employee Benefits Open Enrollment Guide. I understand this sheet does not bind my decision. I must also complete the appropriate enrollment process by the specified deadline.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you have any questions regarding the Benefits Program and/or this form, please contact Central Valley Meat Co.  
 Human Resources Department at (559) 796-0383