Benefits Election Form (Management)
January 1, 2026 through December 31, 2026

Employee Last Name:	**Employee First Name:**	**Employee ID:**
Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed	**Gender:** ❒M ❒F	**Date of Birth:**
Full Address, City, State, and Zip code:		**SSN:** -- --
Date of Hire:	**Phone #:**	**Effective Date:**

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**
❒ **Personify/Anthem – Base PPO $6,350 Ded.**	❒$55.00	❒$225.00	❒$150.00	❒$345.00
❒ **Personify/Anthem – Buy-up PPO $0 Ded.**	❒$80.00	❒$180.00	❒$135.00	❒$230.00
❒ **Delta Dental - Dental PPO (DPPO)**	❒$14.29	❒$29.68	❒$33.02	❒$50.65
❒ **Principal - Vision**	❒$2.74	❒$5.77	❒$5.64	❒$9.24
✓ **The Standard – Life/AD&D Insurance**	✓$ 0	Life Only: ❒ $0	Life Only: ❒ $0	Life Only: ❒ $0
❒**The Standard – Voluntary Life/AD&D**	❒ Employee: $_____	❒ Spouse: $_____	❒ Child(ren): $_____	

Dependent Information

Name	**Relationship**	**Date of Birth**	**Gender**	**Social Security #**	**Check Coverage**:
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $_____
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $_____
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $_____
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $_____

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Dependent Information (continued)					
Name	**Relationship**	**Date of Birth**	**Gender**	**Social Security #**	**Check Coverage**:
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $_____
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒Vol. Life/AD&D Election: $_____
			❒M ❒F		❒Medical ❒Dental ❒Vision ❒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