THE DIXIE GROUP

SALARIED ASSOCIATE ELECTION FORM PLAN YEAR 2020

❑ Open Enrollment Dept: Effective Date:

ASSOCIATE INFORMATION (Please Print)

Date of Hire

First Name | Last Name | M /F | Date of Birth

Address | City | State | Zip Code

❑ Single ❑ Married ❑ Divorced Social Security # Telephone Number:

DEPENDENT INFORMATION

	Med ✓	Den ✓	Vis ✓	First Name	Last Name	Social Security #	Sex	Date of Birth	Student
SELF ❑ Add ❑ Delete									
SPOUSE ❑ Add ❑ Delete									
CHILD ❑ Add ❑ Delete									❑ Yes ❑ No
CHILD ❑ Add ❑ Delete									❑ Yes ❑ No
CHILD ❑ Add ❑ Delete									❑ Yes ❑ No

* If enrolling more than three children, please attach a separate sheet.

ALL AMOUNTS ARE SHOWN ON A SEMI-MONTHLY BASIS

MEDICAL PLANS

Please check one. If enrolling, you must also complete the Health Net or Blue Cross Blue Shield Application.

	Associate Only	Associate & Spouse	Associate & Child(ren)	Associate & Family
Blue Secure PPO - BCBS	❑ $112.75	❑ $241.00	❑ $220.00	❑ $289.25
MVP PPO - BCBS	❑ $46.50	❑ $108.25	❑ $103.00	❑ $122.50
Health & Savings PPO - BCBS	❑ $59.00	❑ $131.00	❑ $124.50	❑ $147.75

❑ DECLINE COVERAGE

DENTAL PLAN

Please check one of the dental plan options listed below. If you are enrolling, you must also complete the appropriate insurance carrier form.

	Associate Only	Associate & Spouse	Associate & Child(ren)	Associate & Family
Indemnity - Delta Dental	❑ $7.50	❑ $14.50	❑ $14.50	❑ $17.00

❑ DECLINE COVERAGE

VISION PLAN

Please check one of the vision plan options listed below. If you are enrolling, you must also complete the appropriate carrier form.

	Associate Only	Associate & One	Associate & Family
Vision Plan - EyeMed	❑ $2.50	❑ $4.74	❑ $6.94

❑ DECLINE COVERAGE

SIGNATURE

I wish to make the choices indicated on this form and authorize The Dixie Group to make any necessary pre-tax deductions for the plan year. I understand that pre-tax contributions will slightly impact my social security contributions. By signing below I certify that the information on this form is complete and accurate and that I have read and understand the fraud warning. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form for my medical, dental, and vision coverage will remain unchanged, although the cost may change. If changes occur during the year that affect this information, I will notify Human Resources within 31 days of the change. I understand that a copy of this form will be made available at my request.

Signature Date