

McMenamin Family ShopRite
2024 Associate Benefit Enrollment
Associate Plan Menu and Contributions



☐ New Hire ☐ Life Event ☐ Open Enrollment

Associate Name: #300 Number:
Social Security Number: Date of Birth:
Home Address:
City: State: Zip:
Signature: Date:

Broad Network

Basic Managed Choice Plan (Bronze)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$22.81**
☐ Associate + Family: **\$39.21**

HCRA Plan (Aetna Healthfund)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$38.50**
☐ Associate + Family: **\$80.69**

☐ **Medical Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

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Associate Name:

Dental: MetLife

MetLife Dental Plan

Associate Contributions (Weekly)

☐ Associate Only: **\$0.00**

☐ Associate + Family: **\$0.00**

☐ **Dental Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

Vision: EyeMed

EyeMed Vision Plan

Associate Contributions (Weekly)

☐ Associate Only: **\$1.00**

☐ Associate + One Eligible Dependent: **\$1.75**

☐ Associate + Family: **\$2.50**

☐ **Vision Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

Flexible Spending Account (FSA) Health Care

Dependent Care

☐ Elect Coverage \$

☐ Elect Coverage \$

☐ **FSA Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

For administration use only.

Associate Hire Date:

Effective Date:

Effective Date Notes:

Billing Store:

Additional Notes:

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Associate Name:

Dependent Enrollment

Please attach applicable Marriage Certificate/Birth Certificate for anyone you are adding.

Name: Date of Birth: Relationship: SSN:

Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:

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