



Farm Credit Foundations Benefit Plans 2008 Benefits Enrollment Form

Name	Social Security #	Date of Hire	Work Phone #
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Note: This form is to be completed by new hires or rehires, and must be returned to Human Resources within 45 days of date of hire. If the form is not returned within 45 days, you will only receive the company paid benefits (Basic Employee Term Life and AD&D, Business Travel Accident, Long-Term Disability Insurance and the Foundations 401(k) Plan). After 45 days, you can only enroll in the optional benefits during the year if you have a qualifying change in status. For more information regarding the following benefit programs and enrollment, refer to the Benefits Guide or the applicable section(s) of the Farm Credit Foundations Benefits Handbook.

Medical Plans

No Coverage – By electing to waive medical, I certify that I have coverage under another plan.

Consumer Choice PPO / HSA

Standard PPO

Premium PPO

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

HMO's/Insured PPO

Some areas have additional choices for medical coverage through HMO's or insured PPO's. Please check with your Benefits Contact to see if this option is available to you.

If you elect an HMO/PPO for your medical coverage, please provide the name of the HMO in the space below and select the desired tier level.

_____ (Please print HMO/PPO name)

Note: Certain tier levels may not be available with all HMO's/PPO's.

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

Employee + One (HMSA plans only)

Dental Plans

Vision Service Plan

Basic

Comprehensive

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

No Coverage

No Coverage

Flexible Spending Accounts

\$ _____ Health Care (enter annual contribution amount)*

\$ _____ Dependent Care (enter annual contribution amount)*

\$ _____ Limited Purpose Healthcare (enter annual contribution amount)*

If you elect the Consumer Choice PPO Plan with HSA, you CANNOT enroll in the FSA Healthcare Account; however, you can enroll in the Limited Purpose Healthcare account.

*Note: The annual amount is the amount that will be deducted from your paychecks for the remainder of the current calendar year. For example, if you elect \$200 and there are two months left in the year, \$50 will be deducted each pay period. The annual contribution limit is \$5,000 for the Health Care or Dependent Care FSA. The annual contribution limit is \$2,500 for the Limited Purpose Healthcare FSA. The minimum contribution per pay period for the Health Care, Dependent Care or Limited Purpose FSA is \$5 per pay period. For more information regarding contribution limits, refer to the Benefits Guide and/or the Flexible Spending Accounts section of the Farm Credit Foundations Benefits Handbook.

Health Savings Account (HSA) - Consumer Choice Participants Only

If you elected the Consumer Choice PPO Plan you will be enrolled in a Health Savings Account (HSA) through Mellon Financial. You may elect to contribute on a pre-tax basis to this account up to the single or family coverage deductible (\$2,900 or \$5,800) minus any employer contribution. (For any period less than 12 months, your maximum contribution is pro-rated based on the number of months enrolled in the plan. Refer to your 2008 Benefits Guide and The Farm Credit Foundations Benefits Handbook for additional information.)

I elect the following 2008 Payroll HSA Deduction \$ _____ (per pay period)

Basic/Optional Basic Employee Term Life and AD&D Insurance

Your employer provides you with Basic Employee Term Life and AD&D coverage equivalent to 1X total compensation. In addition to the employer provided Basic Employee Term Life and AD&D insurance, you may elect 1X Optional Basic Employee Term Life and AD&D coverage.

- Yes, I elect to enroll in the Optional Basic Employee Term Life & AD&D coverage
 No, I do not elect to enroll in the Optional Basic Employee Term Life & AD&D coverage
-

Dependent Child(ren) Life Insurance

You may elect dependent child(ren) coverage in increments of \$5,000 to a maximum of \$25,000.

- \$5000 \$10,000 \$15,000 \$20,000 \$25,000 Waive Coverage
-

Group Universal Life (GUL) Insurance

In order to elect Group Universal Life (GUL) insurance, you are required to complete an online Application form from Minnesota Life at www.lifebenefits.com within 45 days of hire. GUL coverage can be requested at any time. Evidence of insurability may be required for you and/or your spouse if you elect coverage over the guaranteed issue amount. Elections for coverage beyond the maximum allowed without evidence of insurability **will not** be in force until approved by Minnesota Life.

Note: To log onto the LifeBenefits website you will need your User ID (FC + Clock #) and Password. Follow the instructions on the website to enroll in GUL insurance for yourself and/or your spouse and to designate your beneficiaries.

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

You may elect Voluntary AD&D coverage for yourself or for yourself and your dependents. Coverage amounts are between \$25,000 - \$750,000 (in \$25,000 increments) and cannot exceed 10X your **base salary**. If you elect employee plus dependent coverage, your spouse and dependent coverage will be calculated based on the percentages shown below. Maximum coverage for dependent children is \$50,000 per child. (See the Benefits Guide or www.farmcreditfoundations.com for more information.)

- Employee Only Employee plus Dependents \$ _____ Coverage Amount
 [Employee 100% - Spouse 50%/Child(ren) 15%]
 [Employee 100% - Spouse 60%]
 [Employee 100% - Dependent 20%]
 No, I do not elect Voluntary Optional AD&D coverage
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AFLAC

AFLAC supplemental coverage is available to purchase for yourself, your spouse and / or your family. To elect AFLAC coverage, complete the on-line application at www.kansas-afl.com/foundations. Evidence of insurability is required.

401(k) PLAN

After you receive your first computer-generated paycheck (typically within 2-3 weeks from date of hire), you will be eligible to enroll in the Foundations 401(k) Plan. To enroll call New York Life at 1-800-294-3575, or visit their website at www.bcomplete.com.

If you do not enroll, you will automatically be enrolled in the Plan 45 days from your date of hire. The automatic contribution rate is 3% for the first year with an additional 1% contribution added on January 1st each year thereafter until you reach 6%. **At anytime you can increase, decrease, or elect out of the 401(k) Plan** by contacting New York Life Management directly via phone or their website.

Dependent Coverage Information

Name (Last, First)	Relationship (spouse, son, daughter etc.)	Date of Birth (MMDD YYYY) (Required)	Social Security Number	Gender		Full Time College Student*	Disabled Dependent**	Check Box for Coverage Elected			
				F	M			Medical	Dental	Vision	Life Ins (GUL)
				<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*College age dependents, unmarried and under age 25, must be full-time students; full-time status is determined by the college or university.
 **If dependent is disabled, unmarried and dependent on you for support, contact the insurance company directly to provide appropriate documentation (i.e. a letter from physician, which indicates the permanency and nature of the disability).

Authorization

By signing this form, I authorize these elections and any required deductions from my pay. I understand that my elections cannot be changed during the year unless I experience a qualifying change in status. If I elect to waive medical coverage, by signing this form I certify that I have coverage under another medical plan.

Employee Signature _____

Date _____

This form, along with any other applicable forms, must be returned to your local Human Resources Department within 31 days of your date of hire.