

Benefits Enrollment Form

Enables employees to enroll in medical, insurance, and statutory benefit programs.

01 Employee Information

First Name

Last Name

Employee ID

Department

Benefits Effective Date

02 Health Insurance

Health Plan Selection

Coverage Level

03 Additional Benefits

Select additional benefits to enroll in:

- | | |
|---|--|
| <input type="checkbox"/> Dental Insurance | <input type="checkbox"/> Vision Insurance |
| <input type="checkbox"/> Life Insurance | <input type="checkbox"/> Disability Insurance (Short-term) |
| <input type="checkbox"/> Disability Insurance (Long-term) | <input type="checkbox"/> Health Savings Account (HSA) |
| <input type="checkbox"/> Flexible Spending Account (FSA) | <input type="checkbox"/> Wellness Program |

Retirement Plan Selection

04 Dependent Information

Dependent 1 — Name

Date of Birth

Relationship

Dependent 2 — Name

Date of Birth

Relationship

05 Beneficiary Designation

Beneficiary Name

Relationship

Percentage Allocation

Declaration & Consent

By submitting this form, I elect to enroll in the benefits selected above. I understand that my elections will take effect on the date specified and will remain in force until the next open enrollment period unless a qualifying life event occurs. I certify that the dependent and beneficiary information provided is accurate. All data will be handled in accordance with Humii's Privacy Policy.

Authorized Signature

Date (DD/MM/YYYY)

Full Name (Print)

Designation