Terrakotta, Inc. dba Axner

June 1, 2026 to May 31, 2027

FLORIDA Employee Authorization Form

Effective Date:

SECTION A: PERSONAL INFORMATION - Please print clearly

Name (Last, First, MI):	Date of Birth:	Date of Hire:
Street Address:	Social Security #:	
City, State and Zip:	Marital Status: ☐ Single ☐ Married	Gender: ☐ Male ☐ Female

SECTION B: EMPLOYEE AND DEPENDENT COVERAGE - Rates are shown per weekly Paycheck (52 / year)

MEDICAL - Aetna ☐ Decline Medical Reason for Declination: _____

OAMC POS CA25 750 80/60 $20/40 RX3

☐ Employee (EE) Only $39.07 ☐ EE + 1 Dependent $325.56 ☐ EE + 2 or More Dependents $559.96

DENTAL - Aflac ☐ Decline Dental

Low Dental PPO

☐ Employee (EE) Only $3.46 ☐ EE + SP $6.83 ☐ EE + CH(S) $8.91 ☐ EE + Family $12.74

High Dental PPO

☐ Employee (EE) Only $10.13 ☐ EE + SP $20.27 ☐ EE + CH(S) $22.55 ☐ EE + Family $34.33

VISION - Aflac ☐ Decline Vision

Davis 10/25

☐ Employee (EE) Only $1.51 ☐ EE + 1 Dependent $2.98 ☐ EE + 2 or More Dependents $4.41

VOL. LIFE/AD&D - United Healthcare (Late entries are subject to EOI) ☐ Decline Vol. Life/AD&D

Employee: $10,000 to $500,000, not to exceed 5 X Basic Annual Earnings
Spouse: $5,000 not to exceed 50% of Employee Amount
Child(ren): $2,000 to $10,000 not to exceed 50% of Employee Amount

☐ Employee $_____ ☐ Spouse $_____ ☐ Child(ren) $_____

Benefit Amount: EE:_____ SP:_____ CH:_____

WORKSITE BENEFITS - Aflac ☐ ***Continue my current Aflac enrollment with NO changes*** ☐ Decline Aflac

Mark your selection(s): ☐ Accident ☐ Cancer ☐ Critical Care ☐ Disability ☐ Hospital Advantage

LIFE/AD&D - United Healthcare ☒ Employee (EE) Only ***100% paid by Terrakotta, Inc. dba Axner***

*** If making changes to your enrollment or you are enrolling for the first time, please contact Human Resources to obtain the insurance carrier form.***

SECTION C: DEPENDENT INFORMATION - Please print clearly

Dependent Name (Last, First, MI): ☐ Spouse/Domestic Partner ☐ Child	Date of Birth:	Gender: ☐ Male ☐ Female
Address (if different from Employee):	Social Security #:	☐ Add Medical ☐ Remove Medical ☐ Add Dental ☐ Remove Dental ☐ Add Vision ☐ Remove Vision
Dependent Name (Last, First, MI): ☐ Spouse/Domestic Partner ☐ Child	Date of Birth:	Gender: ☐ Male ☐ Female
Address (if different from Employee):	Social Security #:	☐ Add Medical ☐ Remove Medical ☐ Add Dental ☐ Remove Dental ☐ Add Vision ☐ Remove Vision

SECTION D: OTHER INSURANCE COVERAGE - If yes, please complete this section

Medicare Eligible ☐ Yes ☐ No	Other Group Coverage ☐ Yes ☐ No
Name of Subscriber:	Effective Date:
Name of Other Insurance Carrier:	Group Number:

SECTION E: EMPLOYEE SIGNATURE

I elect coverage as indicated above and consent to all terms and conditions stated above. Furthermore, I declare that the information represented above is true and correct. If contributions are required for Group health plan coverage, I authorize my employer to deduct such contributions from earnings via payroll deduction until future notice. My participation in the plan is subject to all the plan terms and conditions as set forth in the plan documents and Summary Plan Description.

SBC: I hereby acknowledge receipt of the Summary of Benefits and Coverage (SBC). I have read the SBC and am familiar with its contents. If I have any questions concerning the information, I will contact the carrier or my Human Resource Department to have my questions answered. I understand this SBC is not a contract, and the material represents guidelines subject to change.

Offer of Coverage: I certify that I have received enrollment and plan information for health care coverage that Terrakotta, Inc. dba Axner offers, representing that it meets ACA requirements for affordable, minimum essential coverage, offering minimum value to me. I have been given the opportunity to enroll in or decline that coverage.

Pre-Tax Payroll Deductions: I authorize any payroll deductions required for the elections I have made above. I understand that these deductions will be made on a pre-tax basis unless I elect otherwise on this form. I understand that I cannot change my elections until the next open enrollment period, but I may change coverage for the dependents I am insuring or add new dependents if there is a "qualified" change in status. I have read the Summary Plan Description and understand the post-tax deduction option.

☐ By checking this box I am declining the tax benefits I would receive under the Section 125 plan pre-tax option, and I understand that my deduction will be taken on a **post-tax basis.**

Employee Signature:	**Date:**

SECTION F: DECLINATION OF COVERAGES – Complete this section only if you NOT want coverage

I understand that insurance coverages have been offered to me and my dependents by Terrakotta, Inc. dba Axner. I decline to participate in the plan at this time. I understand that if I decide to enroll at a later date, I will have to wait until the next Open Enrollment period unless I experience an allowable change event as defined by the Internal Revenue Code (IRC).

Offer of Coverage: I certify that I have received enrollment and plan information for health care coverage that Terrakotta, Inc. dba Axner offers, representing that it meets ACA requirements for affordable, minimum essential coverage, offering minimum value to me. I have been given the opportunity to enroll in or decline that coverage.

Employee Signature:	**Date:**