

**Star Premium Benefits Coverage**  
**1/1/2026-12/31/2026**  
**(See Benefit Plan Summary for details.)**

Employee Name: \_\_\_\_\_ Employee # \_\_\_\_\_ Hire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**NON-SMOKER AGREEMENT: I will not smoke or vape while at work. Initial:** \_\_\_\_\_

**Bi-weekly**  
**Pre-Tax Pay Deduction**  
**Circle Your Selection**

	<u>Employee</u>	<u>Employee &amp; Spouse</u>	<u>Employee &amp; Child/Children</u>	<u>Employee &amp; Family</u>
--	-----------------	------------------------------	--------------------------------------	------------------------------

<b>LV Flex Blue HDHP 6000</b>	<b>\$158.95</b>	\$455.95	\$468.95	\$735.95
-------------------------------	-----------------	----------	----------	----------

<b>LV Flex Blue PPO 4000</b>	<b>\$263.95</b>	\$531.95	\$555.95	\$803.95
------------------------------	-----------------	----------	----------	----------

<b>LV Flex Blue PPO 2000</b>	<b>\$299.95</b>	\$579.95	\$592.95	\$851.95
------------------------------	-----------------	----------	----------	----------

<b>Dental Plan until 06/30/26:</b>	<b>\$10.64</b>	\$35.30	\$35.30	\$35.30
------------------------------------	----------------	---------	---------	---------

<b>Vision Plan until 06/30/26:</b>	<b>\$1.67</b>	\$4.98	\$4.98	\$4.98
------------------------------------	---------------	--------	--------	--------

**I choose to be enrolled in the above circled plan offered by the Star Dealerships:** \_\_\_\_\_

**\*Add a Health Savings Account (HSA) in the amount of \$\_\_\_\_\_ per bi-weekly pay.**

**I decline HighMark Blue Shield medical & drug coverage:** \_\_\_\_\_ **Date** \_\_\_\_\_

**I wish to enroll in the Prudential Life Insurance benefit offered by Star** \_\_\_\_\_

**Spousal Employment Affirmation**

**If you are married and your spouse is employed full-time and has Medical/Rx coverage available to him/her. I understand that my spouse is not considered an eligible dependent under my Medical/RX coverage. Initial** \_\_\_\_\_

**401K:** You have the option to enroll in a 401K Retirement plan after 90 days of employment.  
Please let HR know of your intent to enroll or waive your 401K plan.

\_\_\_\_\_ **I wish to enroll in the 401(k) Retirement Plan.**

\_\_\_\_\_ **I am declining** participation in the 401(k) Retirement Plan.

INFORMATION ABOUT THE ACA GOVERNMENT HEALTHCARE MARKETPLACE CAN BE FOUND AT: [www.healthcare.gov](http://www.healthcare.gov)

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employee Print Name:** \_\_\_\_\_

**\*HSA6000 only**