Aris Group
8120 Penn Ave S. Suite #445
Bloomington MN 55431
952-446-7167
612-806-0965 (fax)

ARIS GROUP
BENEFITS BY DESIGN

WORKPLACE PAYROLL DEDUCTION AUTHORIZATION

Employer Name: **Erdman Automation Corp.**

Employee Name:

Policy Type:	Carrier	PLAN	COVERAGE	Bi-Weekly (26)		Tax Status
Dental	CL					Pre-tax
Vision	CL			$		Pre-tax
Total Payroll Premium				$		

Payroll Frequency: **Bi-Weekly**

Payroll Deductions to begin: **Effective Date 1.1.2026**

I authorize my above named employer to deduct from my salary or wages the Total Payroll Premium as indicated above. I understand that premiums will be sent to the carriers by my employer. In event of a rate change, I authorize a correspondng change in the amount deducted from my earnings.
I understand any *PRE TAX election cannot be changed or revoked* prior to the next plan anniversary date unless due to a change in family status and permitted by my employer.

If any corrections are necessary due to failure to complete, coverage changes or errors in calculation, I authorize the correct amount of premium be deducted for the coverage issued.

Date: _____ Employee Signature: _____

WAIVER

The Insurance Plans made available by my employer have been explained to me. I elect not to participate in these Plans.

Date: _____ Employee Signature: _____

DENTAL	*total*	You Pay
EMPLOYEE	$17.02	$8.51
EMPLOYEE + SPOUSE	$34.05	$25.54
EMPLOYEE +CHILDREN	$34.73	$26.22
EMPLOYEE + FAMILY	$52.47	$43.96

VISION	*total*	You Pay
EMPLOYEE	$3.01	$1.50
EMPLOYEE + SPOUSE	$6.14	$4.64
EMPLOYEE +CHILDREN	$6.22	$4.72
EMPLOYEE + FAMILY	$10.11	$8.60

GROUP MASTER EMPLOYEE ENROLLMENT FORM

Administered by:

Companion Life Insurance Company
800 Main Street
P. O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: (877) 676-5789
Fax: (877) 557-3350

Underwritten by: Companion Life Insurance Company

Companion Life

P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 (Phone) | 800-836-5433 (Fax)

Companion Life Insurance Company			Companion Life Use ONLY
☐ New Employee ☐ Add/Increase Coverage	☐ Change Address ☐ Change Dependent Coverage ☐ Change Class or Status ☐ Terminate Coverage	☐ Change Beneficiary ☐ COBRA	Approved: ☐ Declined: ☐ Date:_____ By: _____

POLICYHOLDER INFORMATION – to be completed by the Policyholder or Group Administrator

Employer Name: ERDMAN AUTOMATION CORP DBA:_____

Group Number:_____ Dept/Div Number:_____ Class:_____

ENROLLEE INFORMATION (PLEASE PRINT)–to be completed by the Employee/Enrollee

Last Name (Include Jr., Sr., etc.)	First Name		M.I.
Street Address	Apt Number	City	State/Zip
Social Security Number	Primary Phone Number Work Phone Number		Email Address
Male ☐ Female ☐	Date of Birth (MM-DD-YY)	☐ Weekly ☐ Monthly ☐ Annually Earnings $_____ Do not include overtime or bonuses	
Marital Status ☐ Married ☐ Single	Occupation	Hours Worked Per Week_____	Hire Date: Coverage Effective Date:

COVERAGE SELECTION

☐ Short-Term Disability
- ☐ 60% to $1,250
- ☐ $100
- ☐ $200

☐ Long-Term Disability
☐ Voluntary Long-Term Disability

☐ Term Life and AD&D
☐ Dependent Term Life
☐ Voluntary Term Life
☐ Voluntary Dependent Term Life
☐ GAP
☐ Critical Illness ☐ Dependent Critical Illness ☐ Accident

☐ Dental
- ☐ High
- ☐ Low

☐ Vision
- ☐ High
- ☐ Low

DEPENDENT INFORMATION			Do any of your Dependents have any other coverage? *(Dental Only)*
Spouse Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No

DEPENDENTS: Eligible Dependents are determined by your Employer's eligibility terms.

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Enrollee.

LONG-TERM DISABILITY

1. **Primary Beneficiary for Employee Coverage/Relationship:**
Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship:
Last First M.I. Relationship to Insured

VOLUNTARY LONG-TERM DISABILITY

1. **Primary Beneficiary for Employee Coverage/Relationship:**
Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship:
Last First M.I. Relationship to Insured

TERM LIFE and DEPENDENT TERM LIFE

1. **Primary Beneficiary for Employee Coverage/Relationship:** *(Employee is beneficiary for spouse coverage)*
Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage)*
Last First M.I. Relationship to Insured

VOLUNTARY TERM LIFE and VOLUNTARY DEPENDENT TERM LIFE

1.**PLAN SELECTION**

☐ Employee ☐ Employee + Spouse ☐ Employee + children ☐ Family

If Voluntary AD&D has been selected by the Employer, your Voluntary AD&D benefit will be equal to the amount of Voluntary Term Life coverage you select.

2. **COVERAGE REQUESTED** ☐ Voluntary Term Life ☐ Voluntary Dependent Term Life

(Amount Selected for Voluntary Life)

EMPLOYEE: $ _____ **SPOUSE:** $ _____ **CHILD:** $ _____

Spouse Name: Last/First/M.I. Birthdate (M/D/Y)

3. **Primary Beneficiary for Employee Coverage/Relationship:** *(Employee is beneficiary for spouse coverage)*
Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage)*
Last First M.I. Relationship to Insured

DENTAL

1. **PLAN SELECTION**

☐ Employee ☐ Employee + Spouse
☐ Employee + children ☐ Family

VISION

1. **PLAN SELECTION**

☐ Employee ☐ Employee + Spouse
☐ Employee + children ☐ Family

GAP

1. **PLAN SELECTION**

☐ Employee ☐ Employee + Spouse ☐ Employee + children ☐ Family

THE POLICY IS A SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THE POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY YOUR CERTIFICATE CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

I understand and acknowledge that no coverage will take effect for myself or dependents, if any, who is not also covered by a Health Benefit Plan, in force at the time of my Requested Effective Date for this coverage.

☐ I confirm that I and my dependents, if any, are currently covered under a Health Benefit Plan or have enrolled for a Health Benefit Plan.

CRITICAL ILLNESS and DEPENDENT CRITICAL ILLNESS

1. **PLAN SELECTION**

☐ Employee
☐ Employee + Dependents

THE POLICY PROVIDES LIMITED BENEFITS. REVIEW YOUR POLICY CAREFULLY. THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THE REQUIREMENTS IN THE FEDERAL AFFORDABLE CARE ACT (ACA). PLEASE CHECK THE POLICY TO UNDERSTAND WHAT THE POLICY COVERS AND DOES NOT COVER (INCLUDING EXCLUSIONS AND TREATMENT LIMITATIONS ON HEALTH BENEFITS OUTSIDE THE SCOPE OF COVERAGE). IF COVERAGE EXPIRES OR ELIGIBILITY FOR COVERAGE UNDER THE POLICY IS LOST, YOU MAY HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO OBTAIN OTHER HEALTH INSURANCE COVERAGE.

HOSPITAL INDEMNITY

1. **PLAN SELECTION**

☐ Employee
☐ Employee + Spouse
☐ Employee + children
☐ Family

THE POLICY IS A SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

The undersigned understands that no benefits will be payable for loss incurred as a result of a pre-existing condition (as defined in the policy) until coverage has been in effect under this plan for 6 consecutive months.

ACCIDENT

1. **PLAN SELECTION**

☐ Employee

☐ Employee + Family

THE POLICY PROVIDES LIMITED BENEFITS. REVIEW YOUR POLICY CAREFULLY. THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THE REQUIREMENTS IN THE FEDERAL AFFORDABLE CARE ACT (ACA). PLEASE CHECK THE POLICY TO UNDERSTAND WHAT THE POLICY COVERS AND DOES NOT COVER (INCLUDING EXCLUSIONS AND TREATMENT LIMITATIONS ON HEALTH BENEFITS OUTSIDE THE SCOPE OF COVERAGE). IF COVERAGE EXPIRES OR ELIGIBILITY FOR COVERAGE UNDER THE POLICY IS LOST, YOU MAY HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO OBTAIN OTHER HEALTH INSURANCE COVERAGE.

AUTHORIZATION FOR DEDUCTION

I elect the coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages. I affirm, to the best of my knowledge and belief, that all information given by me on this form is true and complete. I have read or had read to me any Fraud notice below applicable to my state of issue of this enrollment form.

Enrollee's Signature:_____ **Date:**_____

REFUSAL/WAIVER – Complete ONLY if you are declining one or more offered coverages.

I have been offered insurance coverage as permitted by my Employer and decline to participate in the coverages not selected on the first page. I acknowledge that any coverage offered through my Employer not expressly selected on this application will be considered refused. I understand that in the event I desire such coverage at a later date, I may be required to furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, and the Company shall have the right to refuse any request.

Enrollee's Signature:_____ **Date:**_____

NOTICE TO ENROLLEE – DETACH AND GIVE TO ENROLLEE

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.

Please See Pages 5 - 7 for Companion Life Insurance Company Fraud Notices

FRAUD NOTICE

General Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.