County of Pulaski

July 1, 2020 - June 30, 2021 Plan Election, Enrollment & Premium Confirmation Form

Employee Information

Name:		SSN:	Date of Birth:		Sex: M / F
Address:		City:	State:	Zip:	
Hire Date:	Hours per Week:	Department:	Effective Date:		
Email Address:					

Dependent Information*

***Include all dependents that would be enrolled/termed for the benefit plans offered and indicate you election for each benefit offering below**

A=Add T=Terminate	First	Last	Relationship	Zip (If Different)	Date of Birth:	M / F	SSN
			Spouse				
			Child				
			Child				
			Child				
			Child				
			Child				
			Child				

Anthem - MEDICAL INSURANCE

☐ I accept coverage and authorize payroll deductions. ***Please make selection below.***

Monthly Deduction:	**Anthem Keycare 1400/20% H S A**	**Anthem Keycare 20/40 PPO**
Employee Only	☐ $26.00	☐ $105.00
Employee + Spouse	☐ $193.00	☐ $345.00
Employee + Child	☐ $190.00	☐ $340.00
Employee + Children	☐ $190.00	☐ $340.00
Employee + Family	☐ $328.00	☐ $556.00

☐ I decline Medical coverage. ***Please check reason for declining coverage.***

☐ On spouse's plan ☐ Medicare / Medicaid ☐ Don't want coverage ☐ On Individual Plan
☐ Healthcare.gov / Marketplace ☐ Military

DELTA DENTAL - DENTAL INSURANCE

☐ I accept coverage and authorize payroll deductions. ***Please make selection below.***

Monthly Deduction:	**PPO plus Premier**
Employee Only	☐ $6.00
Employee + Spouse	☐ $9.00
Employee + Child	☐ $10.00
Employee + Children	☐ $10.00
Family	☐ $17.00

☐ I decline Dental coverage.

EYEMED - VOLUNTARY VISION INSURANCE

☐ I accept coverage and authorize payroll deductions. ***Please make selection below.***

Monthly Deduction:	**EyeMed vision - Standard**	**EyeMed vision - Enhanced**
Employee Only	☐ $5.59	☐ $7.18
Employee + Spouse	☐ $10.64	☐ $13.85
Employee + Child	☐ $11.19	☐ $14.51
Employee + Children	☐ $11.19	☐ $14.51
Family	☐ $17.05	☐ $22.35

☐ I decline Vision coverage.

HEALTH SAVINGS ACCOUNT (HSA)

☐ I choose to contribute additonal funds to HSA and authorize payroll deductions.

Annual Additonal Employee Elected Amount of: $

** 2020 IRS Annual Maximum Contributions $3,550 individual or $7,100 family*

Employer Contribution	**Annual Employer Amt.***
Employee Only	$1,260.00
Employee + Spouse	$2,508.00
Employee + Child	$2,508.00
Employee + Children	$2,508.00
Family	$2,508.00

Maximum additonal HSA contribution

IRS Annual Max Contribution		Employer Annual Contribution		Max Additonal Annual Employee Conribution
$3,550.00	-	$1,260.00	=	$2,290.00

IRS Annual Max Contribution		Employer Annual Contribution		Max Additonal Annual Employee
$7,100.00	-	$2,508.00	=	$4,592.00

☐ I decline or am not eligible for HSA Benefits.

PRE-TAX OPT OUT

I certify that the features and benefits under the Cafeteria Plan have been explained to me completetly. I elect to waive all pre-tax benefits under the Plan, and understand that the benefits may be elected on an after-tax basis. Except for change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after -tax coverage shall be outside the Plan.

☐ Waiver of Participation in Pre-Tax premium payment

I understand and agree with the following statements:

• My dependents are not eligible for coverages I don’t have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.

• I represent all information on this form is complete and true to the best of my knowledge.

I declare that the information I have completed on this enrollment form is complete and true.

Your Name (please print):____

Signature____ **Date**________________________