IFS BENEFITS

Benefit Election Form

Please Complete and Return this Benefit Election form to Karen Guyer.

Each employee must complete this form electing or waiving our group benefits. Please check the box for the plans you are electing. If you do not wish to participate in a plan, please check the box marked "waive" and indicate the reason. **This form is not an official insurance company enrollment form and DOES NOT replace the insurance carrier form(s). It is merely designed to simplify benefits administration.**

GROUP NAME: People's Place, Inc.

EMPLOYEE NAME: ______________________

MEDICAL INSURANCE

Everyone must complete an Aetna Enrollment/Waiver Form.

I choose the following **Aetna** health insurance coverage:

☐ PPO 2000 80/50 HSA T

Select Tier	Pre-taxed Payroll Deduction
☐ Employee	$ 28.46 per pay
☐ Employee + Spouse	$ 378.32 per pay
☐ Employee + Child(ren)	$ 278.21 per pay
☐ Family	$ 567.92 per pay

☐ PPO 2000 100/50 $30

Select Tier	Pre-taxed Payroll Deduction
☐ Employee	$ 126.27 per pay
☐ Employee + Spouse	$ 620.19 per pay
☐ Employee + Child(ren)	$ 466.47 per pay
☐ Family	$ 902.96 per pay

☐ Waive

Select Reason for Waiving Coverage
☐ Covered by Spouse
☐ Covered by Individual
☐ Other: ______________________

***This is not a contract or a definitive statement of benefits. It is intended solely to provide you with an overview of your benefits. Complete details of benefits, terms and exclusions are governed by your Group Membership Agreement.*

HSA CONTRIBUTIONS

If you enroll in the HSA plan, you may elect to deposit money directly into the HSA through pre-tax payroll deductions. Complete below if you are electing this option.

☐ **HSA Contributions**

For calendar year 2018, the annual limits are $3,450 (single) and $6,850 (family). Amount may be less if not participating for a full 12 months.

Annual HSA Election Amount		#of Paychecks		Amount per Paycheck
$	÷	26	=	$

☐ **Waive HSA Contributions**

FLEXIBLE SPENDING ACCOUNT (FSA)

You must complete an Ameriflex Enrollment Form if enrolling in the Flexible Spending Account.

☐ **Flexible Spending Account (FSA)**

The maximum annual medical account election available for 2018 is $2,650 and the annual dependent care amount is $5,000.

Select Type	Annual Election Amount		#of Paychecks		Pre-taxed Amount per Paycheck
☐ Medical	$	÷	26	=	$
☐ Dependent Care	$	÷	26	=	$

☐ **Waive FSA**

VISION INSURANCE

If making changes to your current elections, or enrolling for the first time, you must complete a VSP Enrollment Form.

I choose the following **VSP** Vision insurance coverage. Pre-taxed Payroll deductions are as follows:

☐ **Vision**

Select Tier	Pre-taxed Payroll Deduction
☐ Employee	$ 3.75 per pay
☐ Employee + Spouse	$ 6.00 per pay
☐ Employee + Child(ren)	$ 6.12 per pay
☐ Family	$ 9.87 per pay

☐ **Waive Vision Coverage**

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DENTAL INSURANCE

If making changes to your current elections, or enrolling for the first time, you must complete a Delta Enrollment Form.

I choose the following **Delta** Dental insurance coverage. Pre-taxed Payroll deductions are as follows:

☐ High Plan

Select Tier	Pre-taxed Payroll Deduction
☐ Employee	$ 15.54 per pay
☐ Employee + Spouse	$ 31.60 per pay
☐ Employee + Child(ren)	$ 35.83 per pay
☐ Family	$ 54.47 per pay

☐ Low Plan

Select Tier	Pre-taxed Payroll Deduction
☐ Employee	$ 13.32 per pay
☐ Employee + Spouse	$ 27.16 per pay
☐ Employee + Child(ren)	$ 31.21 per pay
☐ Family	$ 47.42 per pay

☐ Waive Dental Coverage

Select Reason for Waiving Coverage
☐ Covered by Spouse
☐ Covered by Individual
☐ Other: ______________________

VOLUNTARY LIFE

Enter amount of your voluntary elected Life insurance on the line provided below. Also enter the pay deduction associated with that amount.

☐ Voluntary Life

Select all that apply	Amount Elected	Payroll Deduction
☐ Employee	$	$
☐ Spouse	$	$
☐ Child	$	$

Payroll deductions for Voluntary Life coverage will be deducted *after-tax* so that benefits accessed will be received tax-free.

☐ Waive Voluntary Life

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I authorize People's Place, Inc. to make the applicable pre-tax, per pay deductions from my paycheck, as a contribution towards my benefits.

I understand the coverage I have elected is in effect until May 31, 2019 and I cannot make any changes until that point unless I experience a qualifying event. I understand that if I have waived coverage, I will be unable to enroll until the next annual open enrollment unless I experience a qualifying event. If I am currently covered elsewhere and experience a change in coverage, I must notify the HR Dept. promptly to be eligible for participation.

****If enrolling in Health Insurance, I acknowledge that I have received the *Summary of Benefits and Coverage* (SBC) for the health insurance plan elected.**

I also acknowledge that I have received the Required Notices for the 2018 Plan year.

I understand this form is not an official insurance company enrollment form, and is designed to simplify benefits administration for my employer. I will return this completed form to Karen Guyer.

Employee Signature _______________________________ **Date** ____________________

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