IFS BENEFITS

Benefit Election Form

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

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

Please indicate if you are making changes to your current elections or enrolling for the first time:

- ☐ **Enrolling in Medical for the first time:** You MUST COMPLETE an enrollment form
- ☐ **Currently enrolled in Medical with CHANGES:** You MUST COMPLETE an enrollment form
- ☐ **Currently enrolled in Medical with NO CHANGES:** No enrollment form required

I choose one of the following medical insurance coverage. Pre-taxed Payroll deductions are as follows:

☐ **DE OAMC 2500 100/50 HSA T**

Select Tier	Per Pay Deduction (Pre-taxed)
☐ Employee	$ 45.25
☐ Employee + Spouse	$ 429.76
☐ Employee + Child(ren)	$ 326.09
☐ Family	$ 647.91

☐ **DE OAMC 2500 100/50 $20/40**

Select Tier	Per Pay Deduction (Pre-taxed)
☐ Employee	$ 126.26
☐ Employee + Spouse	$ 620.19
☐ Employee + Child(ren)	$ 466.46
☐ Family	$ 902.95

☐ **Waive Medical**

Select Reason for Waiving Medical Coverage

☐ **Covered by Spouse** ☐ **Covered by Individual** ☐ **Other:** _____

HSA CONTRIBUTIONS

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

☐ **Elect HSA Contribution**

For calendar year 2021, the annual limits are **$3,600** (single) and **$7,200** (family). These limits are $1,000 higher for individuals age 55 or older at any time during the year. Amount may be less if not participating for a full 12 months.

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

☐ **Waive HSA Contribution**

FLEXIBLE SPENDING ACCOUNT (FSA)

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

☐ **Elect FSA Contribution**

The 2021 calendar year medical account maximum election is $2,750.
The 2021 calendar year dependent care maximum election is $5,000.
If you enroll in the HSA plan, you are not eligible for the medical FSA.

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

☐ **Waive FSA Contribution**

VISION INSURANCE

Please indicate if you are making changes to your current elections or enrolling for the first time:

☐ **Enrolling in Vision for the first time:** You MUST COMPLETE an enrollment form
☐ **Currently enrolled in Vision with CHANGES:** You MUST COMPLETE an enrollment form
☐ **Currently enrolled in Vision with NO CHANGES:** No enrollment form required

☐ **Elect Vision**

Select Tier	Per Pay Deduction (Pre-taxed)
☐ **Employee**	$ 3.75
☐ **Employee + Spouse**	$ 6.00
☐ **Employee + Child(ren)**	$ 6.12
☐ **Family**	$ 9.87

☐ **Waive Vision**

***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.*

DENTAL INSURANCE

Please indicate if you are making changes to your current elections or enrolling for the first time:

- ☐ **Enrolling in Dental for the first time:** You MUST COMPLETE an enrollment form
- ☐ **Currently enrolled in Dental with CHANGES:** You MUST COMPLETE an enrollment form
- ☐ **Currently enrolled in Dental with NO CHANGES:** No enrollment form required

☐ **Elect High Option Plan Dental**

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

☐ **Elect Low Option Plan Dental**

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

☐ **Waive Dental**

Select Reason for Waiving Dental Coverage

☐ Covered by Spouse ☐ Covered by Individual ☐ Other: _____

VOLUNTARY LIFE

Please indicate if you are making changes to your current elections or enrolling for the first time:

- ☐ **Enrolling in Vol Life for the first time:** You MUST COMPLETE an enrollment form and EOI
- ☐ **Currently enrolled in Vol Life with CHANGES:** You MUST COMPLETE an enrollment form and EOI
- ☐ **Currently enrolled in Vol Life with NO CHANGES:** No enrollment form required (Leave below blank)

☐ **Elect Voluntary Life**

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

Payroll deductions for Voluntary 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 and post-tax, per pay deductions from my paycheck, as a contribution towards my benefits.

I understand the coverage I have elected is in effect until 05/31/2022, 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 2021 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 or Ashley Parker.

Employee Signature **Date**

_____ _____

Print Name

_____

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