People's Place

Forms Due May 12th by noon

Benefits Election & Payroll Deduction Form

People's Place is offering the following benefit plans. Please make your selections below, sign and return this form to Karen Guyer. If you are enrolling during open enrollment your elections will take effect on June 1, 2017.

If you do not wish to participate in a plan, please check the box marked "waive" and indicate the reason.

Employee Name **Employee #**

MEDICAL INSURANCE (Full-time Employees, please also complete enrollment form)

I choose the following health insurance coverage:

☐ **HSA $2,000/$4,000 (Health Savings Account) *** If more than one person is enrolled in the HSA, no individual family member's deductible or out of pocket is considered satisfied until the full family deductible or out of pocket has been met.

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Please choose one of the following coverage categories:

- ☐ **HSA Employee** $52.04 per pay
- ☐ **HSA Employee + Spouse** $385.55 per pay
- ☐ **HSA Employee + Child(ren)** $260.20 per pay
- ☐ **HSA Family** $560.12 per pay

Or

☐ **AFS5 $2,000/$4,000**

Please choose one of the following coverage categories:

- ☐ **Employee** $149.97 per pay
- ☐ **Employee + Spouse** $610.75 per pay
- ☐ **Employee + Child(ren)** $437.12 per pay
- ☐ **Family** $851.54 per pay

*** Waive Medical Insurance-** The first time you waive medical insurance you must complete section A & B of the United Healthcare enrollment form. If you completed the United Healthcare form in a previous year to waive coverage you may complete the below section.

Waive Medical Insurance – Reason for waiving: ☐ Covered by another plan ☐ Waive / No Coverage

HSA (HEALTH SAVINGS ACCOUNT Full-time Employees)

☐ Health Savings Account ***First time enrollees must complete enrollment form.

☐ Waive

If you enroll in the **H S A plan**, you may elect to deposit money directly into the H S A through pre-tax payroll deductions. All employees that wish to contribute to an HSA must complete an enrollment form. For calendar year 2018, the annual HSA contribution limits are $3350 (single) and $6750 (family). Complete below if you are electing this option. ***Amount may be less if not participating for a full 12 months.***

$\_\_\_\_\_ ÷ **26** = **$**_____

Annual H S A Election Amount | Number of Paychecks | Amount per Paycheck

FLEXIBLE SPENDING (Full-time Employees)

☐ Flexible Spending Account ***First time enrollees must complete enrollment form.

☐ Waive

The maximum annual medical account election is $2,600. Those enrolling in the H S A are not eligible to participate in the FSA. Regardless of medical plan election all employees may elect up to the annual dependent care amount of $5,000.

$_____ ÷ _____26_____ = $_____

Annual F S A Election Amount | Number of Paychecks | Amount per Paycheck

Dental, Vision enrollment forms are needed ONLY if you are changing plans, changing coverage levels or enrolling for the first time.

DELTA DENTAL INSURANCE (Full-time & Part-time Employees)

I choose the following Dental insurance coverage:

☐ No change, I'm keeping my plan the same as last year.

High Option	Low Option
☐ **Employee** $15.54 per pay	☐ **Employee** $13.32 per pay
☐ **Employee + Spouse** $31.60 per pay	☐ **Employee + Spouse** $27.16per pay
☐ **Employee + Child(ren)** $35.83 per pay	☐ **Employee + Child(ren)** $31.21 per pay
☐ **Family** $54.47 per pay	☐ **Family** $47.42 per pay

Waive Dental Insurance– Reason for Waiving:_____

☐ Covered by another plan ☐ Waive / No Coverage

VSP VISION INSURANCE (Full-time & Part-time Employees)

I choose the following Vision insurance coverage:

☐ No change, I'm keeping my plan the same as last year.

Please choose one of the following coverage categories:

☐ **Employee** $3.75 per pay

☐ **Employee + Spouse** $6.12 per pay

☐ **Employee + Child(ren)** $6.00 per pay

☐ **Family** $9.87 per pay

Waive VSP Insurance – Reason for waiving:_____

☐ Covered by another plan ☐ Waive / No Coverage

My signature below indicates that:

I authorize People's Place to deduct the applicable per pay deductions from my paycheck, as a contribution towards the benefits that I have elected.

I understand the coverage I have elected is in effect June 1, 2017- May 31, 2018, 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 benefit coverage for the health insurance plan I elected. I also acknowledge that I have received the Required Notices for the 2017 Plan year.

Employee Signature _____ Date _____

All Forms are Due May12th by noon.