County of Pulaski

July 1, 2023 - June 30, 2024 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 your 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	☐ $6.39	☐ $8.21
Employee + Spouse	☐ $12.17	☐ $15.84
Employee + Child	☐ $12.80	☐ $16.60
Employee + Children	☐ $12.80	☐ $16.60
Family	☐ $19.51	☐ $25.57

☐ 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: $_____

** 2021 IRS Annual Maximum Contributions $3,600 individual or $7,200 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

$3,600.00	-	$1,260.00	=	$2,340.00
IRS Annual Max Contribution		Employer Annual Contribution		Max Additonal Annual Employee Conribution
$7,200.00	-	$2,508.00	=	$4,692.00
IRS Annual Max Contribution		Employer Annual Contribution		Max Additonal Annual Employee

☐ 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**_____