Attica Consolidated School Corporation

2020 Open Enrollment Benefit Elections

ATTICA

Step 1	Complete this Benefits Election Form
Step 2	Complete an Evidence of Insurability Form if you are enrolling in voluntary life for the 1st time or increasing coverage.
Step 3	Return all forms to Deanna Hutts by September 2, 2020

Last Name, First Name	Gender: ☐ Male ☐ Female	Social Security Number:
Street Address:		
City, State, Zip Code:		
Date of Birth:	Date of Hire	
Salary	Occupation	Hours worked per week

Please indicate desired coverage for each dependent below.

	Name	DOB	SSN	Gender	Med	Dental	Vision	Vol Life
Spouse:	____________	______	________	☐ M | ☐ F	☐	☐	☐	☐
Child:	____________	______	________	☐ M | ☐ F	☐	☐	☐	☐
Child:	____________	______	________	☐ M | ☐ F	☐	☐	☐	☐
Child:	____________	______	________	☐ M | ☐ F	☐	☐	☐	☐
Child:	____________	______	________	☐ M | ☐ F	☐	☐	☐	☐
Child:	____________	______	________	☐ M | ☐ F	☐	☐	☐	☐

☐	**No Change –** Maintain current plan enrollment for myself and any dependents enrolled
☐	**Decline Coverage**
☐	**New Enrollment –** Not currently enrolled in either plan
☐	**Change family members enrolled**
☐	**Plan Change Only**

Anthem Medical Per Pay Cost		
	HSA	**PPO**
Employee Only	☐ $87.15	☐ $86.95
Employee + 1	☐ $174.24	☐ $171.34
Employee + Family	☐ $213.91	☐ $239.84

I choose to waive medical coverage

☐

☐	I elect to contribute $______________________ per pay to my Health Savings Account
☐	Decline payroll contribution

☐	**No Change** – Maintain current plan enrollment for myself and any dependents enrolled
☐	**Decline Coverage**
☐	**New Enrollment** – Not currently enrolled
☐	**Change family members enrolled**

Guardian Dental Per Pay Cost	
Employee Only	☐ $0.00
Employee + Spouse	☐ $16.51
Employee + Child(ren)	☐ $24.67
Employee + Family	☐ $50.27

☐ **I choose to waive dental coverage**

☐	**No Change** – Maintain current plan enrollment for myself and any dependents enrolled
☐	**Decline Coverage**
☐	**New Enrollment** – Not currently enrolled
☐	**Change family members enrolled**

VSP Vision Per Pay Cost	
Employee Only	☐ $0.00
Employee + Spouse	☐ $0.00
Employee + Child(ren)	☐ $0.00
Employee + Family	☐ $0.00

☐ I choose to waive vision coverage

NO PAYROLL DEDUCTIONS. GROUP LIFE AND AD&D IS PAID FOR BY ATTICA CONSOLIDATED SCHOOL CORP		
Primary Beneficiary	Relationship	Percentage
Contingent Beneficiary	Relationship	Percentage

☐	**No Change –** Maintain current plan enrollment for myself and any dependents enrolled
☐	**Decline Coverage**
☐	**New Enrollment** – Not currently enrolled in either plan
☐	**Change Benefit Amount –** Guardian Evidence of Insurability Form Required

If you are electing voluntary life coverage for the first time, changing your benefit amount, or are adding dependents to your coverage, you must complete the Guardian Evidence of Insurability Form.

PAYROLL DEDUCTION BASED ON 24 PAYS PER YEAR		
	Amount of Coverage Elected	**Cost Per Pay**
Employee		
Spouse		
Child(ren)		

I choose to waive voluntary life coverage

Primary Beneficiary	Relationship	Percentage
☐		
Contingent Beneficiary	Relationship	Percentage

PAYROLL DEDUCTION BASED ON 24 PAYS PER YEAR		
	Amount of Coverage Elected	**Cost Per Pay**
Employee		

☐ I choose to waive voluntary short-term disability coverage

☐	I authorize Attica Consolidated School Corporation to make the above mentioned payroll deductions for medical and dental coverage on a **pre-tax** basis.
☐	Deductions for the above mentioned elections should be made on a **post-tax** basis.

I understand that I cannot change or revoke this election at any time during the Plan Year unless I have a qualifying life event change (i.e. marriage, divorce, death, birth or adoption of a child, termination of spouse's coverage or employment). In addition, if I have declined coverage, I understand that I am not eligible again until the annual open enrollment, unless I have a change in family status or qualifying HIPAA event as described above.

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Name *(please print)*

____ ____________________

Signature Date