



**HOW TO MAKE BENEFIT ELECTIONS**

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

**PART I: EMPLOYEE INFORMATION**

Last Name, First Name		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:
Street Address:			
City, State, Zip Code:			
Date of Birth:		Date of Hire	
Salary	Occupation	Hours worked per week	

**PART II: DEPENDENT INFORMATION**

**Please indicate desired coverage for each dependent below.**

Name	DOB	SSN	Gender	Med	Dental	Vision	Vol Life
Spouse: _____	_____	_____	<input type="checkbox"/> M   <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child: _____	_____	_____	<input type="checkbox"/> M   <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child: _____	_____	_____	<input type="checkbox"/> M   <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child: _____	_____	_____	<input type="checkbox"/> M   <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child: _____	_____	_____	<input type="checkbox"/> M   <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child: _____	_____	_____	<input type="checkbox"/> M   <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART III: MEDICAL**

<input type="checkbox"/>	<b>No Change</b> – Maintain current plan enrollment for myself and any dependents enrolled
<input type="checkbox"/>	<b>Decline Coverage</b>
<input type="checkbox"/>	<b>New Enrollment</b> – Not currently enrolled in either plan
<input type="checkbox"/>	<b>Change family members enrolled</b>
<input type="checkbox"/>	<b>Plan Change Only</b>

Anthem Medical Per Pay Cost		
	HSA	PPO
Employee Only	<input type="checkbox"/> \$78.91	<input type="checkbox"/> \$91.23
Employee + 1	<input type="checkbox"/> \$157.77	<input type="checkbox"/> \$179.91
Employee + Family	<input type="checkbox"/> \$190.84	<input type="checkbox"/> \$251.83

**I choose to waive medical coverage**



**PART IV: HSA CONTRIBUTIONS**

<input type="checkbox"/>	I elect to contribute \$_____ per pay to my Health Savings Account
<input type="checkbox"/>	Decline payroll contribution

**PART V: DENTAL**

<input type="checkbox"/>	<b>No Change</b> – Maintain current plan enrollment for myself and any dependents enrolled
<input type="checkbox"/>	<b>Decline Coverage</b>
<input type="checkbox"/>	<b>New Enrollment</b> – Not currently enrolled
<input type="checkbox"/>	<b>Change family members enrolled</b>

Guardian Dental Per Pay Cost	
Employee Only	<input type="checkbox"/> \$0.00
Employee + Spouse	<input type="checkbox"/> \$16.51
Employee + Child(ren)	<input type="checkbox"/> \$24.67
Employee + Family	<input type="checkbox"/> \$50.27

**I choose to waive dental coverage**



**PART VI: VISION**

<input type="checkbox"/>	<b>No Change</b> – Maintain current plan enrollment for myself and any dependents enrolled
<input type="checkbox"/>	<b>Decline Coverage</b>
<input type="checkbox"/>	<b>New Enrollment</b> – Not currently enrolled
<input type="checkbox"/>	<b>Change family members enrolled</b>

VSP Vision Per Pay Cost	
Employee Only	<input type="checkbox"/> \$0.00
Employee + Spouse	<input type="checkbox"/> \$0.00
Employee + Child(ren)	<input type="checkbox"/> \$0.00
Employee + Family	<input type="checkbox"/> \$0.00

**I choose to waive vision coverage**



**PART VII: GROUP LIFE**

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



**PART VIII: VOLUNTARY LIFE**

<input type="checkbox"/>	<b>No Change</b> – Maintain current plan enrollment for myself and any dependents enrolled
<input type="checkbox"/>	<b>Decline Coverage</b>
<input type="checkbox"/>	<b>New Enrollment</b> – Not currently enrolled in either plan
<input type="checkbox"/>	<b>Change Benefit Amount</b> – 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



**PART VIII: SECTION 125**

<input type="checkbox"/>	I authorize Attica Consolidated School Corporation to make the above mentioned payroll deductions for medical and dental coverage on a <b>pre-tax</b> basis.
<input type="checkbox"/>	Deductions for the above mentioned elections should be made on a <b>post-tax</b> 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.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date