

Attica Consolidated School Corporation
 2022 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 1 st time or increasing coverage.
Step 3	Return all forms to Deanna Hutts by September 16, 2022

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	

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"/>

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

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



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

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

Guardian Dental Per Pay Cost	
Employee Only	<input type="checkbox"/> \$0.00
Employee + Spouse	<input type="checkbox"/> \$18.98
Employee + Child(ren)	<input type="checkbox"/> \$28.37
Employee + Family	<input type="checkbox"/> \$57.81

I choose to waive dental coverage



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

VSP Vision Per Pay Cost	
Employee Only	<input type="checkbox"/> \$0.00 / \$0.00
Employee + 1	<input type="checkbox"/> \$0.00 / \$7.15
Family	<input type="checkbox"/> \$0.00 / \$10.73

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



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



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

Name (please print)

Signature

Date