Name

Location

July 1, 2023-June 30, 2024 Plan Election and Premium Confirmation Form

AETNA MEDICAL INSURANCE

☐ I accept coverage and authorize payroll deductions. ***Please make selection below*** .

☐ 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

☐ Currently Enrolled - No Change

☐ Qualifying Life Event/Update

Reason for change: _____

☐ New Hire

Payroll Deductions (*per payroll*)		Aetna HNOption HSA $3000/0%/6900		Aetna HNOption 30/1000/30%	Monthly Cost HSA Plan	Monthly Cost $1K Plan
Employee Only		$0.00		$79.50	$0.00	$159.00
Employee + Spouse		$252.76		$530.78	$505.52	$1,061.56
Emp + Spouse (2 EE's)		$0.00		$106.20	$0.00	$212.40
Employee + Child		$95.37		$303.97	$190.74	$607.94
Employee + Children		$95.37		$303.97	$190.74	$607.94
Employee + Family		$441.45		$994.51	$882.90	$1,989.02
Emp. + Family (2 EE's)		$0.00		$571.06	$0.00	$1,142.12

DELTA DENTAL VOLUNTARY DENTAL INSURANCE

☐ I accept coverage and authorize payroll deductions. ***Please make selection below*** .

☐ I decline Dental coverage.

☐ Currently Enrolled - No Change

☐ Qualifying Life Event/Update

Reason for change: _____

☐ New Hire

Payroll Deductions (*per payroll*)		Voluntary Dental Basic		Voluntary Dental Premium	Monthly Cost Basic	Monthly Cost Premium
Employee Only		$12.27		$19.09	$24.54	$38.18
Employee + Spouse		$26.17		$40.71	$52.34	$81.42
Employee + Child(ren)		$27.09		$42.16	$54.18	$84.32
Employee + Family		$41.79		$65.02	$83.58	$130.04

HealthEquity Health Savings Account (HSA)

☐ Employer AND Employee funded - please create an account for me.

☐ I decline this account.

HealthEquity FLEXIBLE SPENDING ACCOUNT (FSA)

☐ Employee paid - please ENROLL me in this account. I understand I must complete the carrier enrollment.

☐ I decline Voluntary Employee Paid FSA benefits.

TRANSAMERICA VOLUNTARY ACCIDENT INSURANCE

☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment. ***Please see HR for rates and forms.***

☐ I decline Voluntary Employee Paid Benefits.

☐ Currently Enrolled - No Change

TRANSAMERICA VOLUNTARY CRITICAL ILLNESS INSURANCE

☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment AND Evidence of Insurability forms, and must be approved through their underwriting process before the benefit will begin. ***Please see HR for rates and forms.***

☐ I decline Voluntary Employee Paid Benefits.

☐ Currently Enrolled - No Change

AirMedCare Network

☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment. ***Please see HR for rates and forms.***

☐ I decline Voluntary Employee Paid Benefits.

I have been offered the above employee benefit options and I have selected my choices. I agree to allow my employer to deduct the appropriate premium(s) from my wages. I also understand I may not change coverage or family status unless I have a qualifying event or until the next open enrollment.

Signature

Date