Taylor School District

2020 Employee Benefit Election Form

THIS FORM MUST BE RETURNED BY ALL EMPLOYEES

Due Date: Friday November 15, 2019

Employee Election for 2020

☐ For the 2020 year I am electing to continue with the same benefits I currently have in place from the 2019 election. The amount I desire to have withheld from my paycheck for my H.S.A. Account annually, if applicable, is $_____ and Taylor will send directly to my HealthEquity HSA Account*. The cost for the medical plans for 2020 are shown below. Please complete this section and the signature section at the end of this form.

-**No contributions can be made into an HSA Account if you are enrolled in Medicare**

☐ I am requesting changes to my current benefits, other than the amount for my HSA Account, and know I must complete the remainder of this form.

Last Name	First Name	Social Security #	Marital Status ☐ Single ☐ Married ☐ Divorced

Street Address	City	State	Zip Code

Medical Plans – Please choose one of the following:

Cash In Lieu

☐ I am electing the monthly health cash option payment of $160. **A separate form is required in order to receive benefit.**

HAP HMO HSA	Premium	Hard Cap 2020	Monthly Employee Portion	Payroll deduct on 26 pays*	Payroll Deduct on 20 Pays*
☐ Single	$597.72	$568.24	$29.48	$13.61	$17.69
☐ Two Person	$1,249.23	$1,188.36	$60.87	$28.09	$36.52
☐ Family	$1,613.83	$1,549.75	$64.08	$29.58	$38.45
$_____ Annual HSA Election to be deducted by pay and sent to the HealthEquity HSA Account					

HAP HMO	Premium	Hard Cap 2020	Monthly Employee Portion	Payroll deduct on 26 pays*	Payroll Deduct on 20 Pays*
☐ Single	$730.27	$568.24	$162.03	$74.78	$97.22
☐ Two Person	$1,526.25	$1,188.36	$337.89	$155.95	$202.73
☐ Family	$1,971.71	$1,549.75	$421.96	$194.75	$253.18

Dental Plan – Please choose one of the following:	
Cash In Lieu	

☐ I am electing the monthly dental cash option payment of $15. A separate form is required.

Delta Dental	Premium		Monthly Employee Portion	Payroll Deduct on 26 Pays*	Payroll Deduct on 20 Pays*
☐ Single	$36.00		$0.00	$0.00	$0.00
☐ Two Person	$68.06		$0.00	$0.00	$0.00
☐ Family	$128.99		$0.00	$0.00	$0.00

***Employer determines payroll cycle**

Vision Plan – Please choose one of the following:		
Cash In Lieu		

☐ I am electing the monthly vision cash option payment of $5. A separate form is required.

Teachers		

☐ I am a teacher and understand I will have the District reimbursement plan

NVA Vision	Premium		Monthly Employee Portion	Payroll Deduct on 20 Pays*
☐ Single	$4.80		$1.30	$0.78
☐ Two Person	$9.07		$2.94	$1.78
☐ Family	$12.80		$3.52	$2..12

List all persons to be enrolled or terminated

	Check One	Last Name	First Name	Gender	Date of Birth MM/DD/YYYY	Social Security Number	Plan Elections
Employee	☐ Enroll ☐ Term			☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
Spouse	☐ Maintain ☐ Enroll ☐ Term			☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
Dep-1	☐ Maintain ☐ Enroll ☐ Term			☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
Dep-2	☐ Maintain ☐ Enroll ☐ Term			☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision

Dep-3	☐ Maintain ☐ Enroll ☐ Term			☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision
Dep-4	☐ Maintain ☐ Enroll ☐ Term			☐ M ☐ F			☐ Medical ☐ Dental ☐ Vision

LIMITED PURPOSE Flexible Spending Account – A separate form is required for an annual election.

☐ I am enrolling in the LIMITED PURPOSE Flexible Spending Account

☐ I am declining to enroll in the Flexible Spending Account

Disability Insurance (*New Hires Only*)

☐ Long Term Disability – Salary employees only

☐ Short Term Disability – Hourly employees only

Life Insurance (*New Hires Only*)

☐ Life Insurance and Accidental Death or Dismemberment

Attestation

I understand that:

☒ My required contribution for coverage will be deducted from my pay on a Pre-Tax (before tax) basis.

☒ Required Contributions are the amounts I must pay for coverage (for myself and my dependents)

☒ I cannot change or revoke my coverage during the plan year unless I have a change in family status (this includes marriage; divorce; death of a spouse; birth, death, adoption of a child; or termination of employment of a spouse) or other such events as allowed by the Plan.

☒ By reducing my compensation on a before-tax basis, my Social Security benefits may be reduced.

☒ I will be notified of any subsequent change in the required contribution.

This agreement is subject to the terms of the Taylor School District Employee Benefit Plan, as may be amended, and revokes any prior election and compensation reduction agreement relating to the premium conversion plan.

Each year during the annual Open Enrollment period, I will have an opportunity to change my election.

Employee ID: _____

_____ _____

Employee Signature Date

***Employer determines payroll cycle**