

# Taylor School District

## 2021 Employee Benefit Election Form

**THIS FORM MUST BE RETURNED BY ALL EMPLOYEES**

**Due Date: Friday November 6, 2020**

Last Name	First Name	Social Security #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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*
<input type="checkbox"/> Single	\$597.72	\$586.99	\$10.73	\$4.95	\$6.44
<input type="checkbox"/> Two Person	\$1,249.23	\$1,227.58	\$21.65	\$9.99	\$12.99
<input type="checkbox"/> Family	\$1,613.83	\$1,600.89	\$12.94	\$5.97	\$7.76
\$_____ 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*
<input type="checkbox"/> Single	\$730.27	\$586.99	\$143.28	\$66.13	\$85.97
<input type="checkbox"/> Two Person	\$1,526.25	\$1,227.58	\$298.67	\$137.85	\$179.20
<input type="checkbox"/> Family	\$1,971.71	\$1,600.89	\$370.82	\$171.15	\$222.49

**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	Hard Cap 2020	Monthly Employee Portion	Payroll Deduct on 26 Pays*	Payroll Deduct on 20 Pays*
<input type="checkbox"/> Single	\$36.00		\$0.00	\$0.00	\$0.00
<input type="checkbox"/> Two Person	\$68.06		\$0.00	\$0.00	\$0.00
<input type="checkbox"/> 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*
<input type="checkbox"/> Single	\$4.80	\$1.30	\$0.78
<input type="checkbox"/> Two Person	\$9.07	\$2.94	\$1.78
<input type="checkbox"/> Family	\$12.80	\$3.52	\$2..12

**Employee and Dependent Information**

*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	<input type="checkbox"/> Maintain <input type="checkbox"/> Enroll <input type="checkbox"/> Term			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Spouse	<input type="checkbox"/> Maintain <input type="checkbox"/> Enroll <input type="checkbox"/> Term			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dep-1	<input type="checkbox"/> Maintain <input type="checkbox"/> Enroll <input type="checkbox"/> Term			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dep-2	<input type="checkbox"/> Maintain <input type="checkbox"/> Enroll <input type="checkbox"/> Term			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dep-3	<input type="checkbox"/> Maintain <input type="checkbox"/> Enroll <input type="checkbox"/> Term			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dep-4	<input type="checkbox"/> Maintain <input type="checkbox"/> Enroll <input type="checkbox"/> Term			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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

**\*Employer determines payroll cycle**

\_\_\_\_\_  
Date

