Taylor School District
2017 Benefit Enrollment or Election Form

THIS FORM MUST BE RETURNED BY ALL EMPLOYEES

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 PPO Option 1	Premium	Hard Cap 2017	Monthly Employee Portion	Payroll deduct on 26 pays*	Payroll Deduct on 20 Pays*
☐ Single	$722.86	$528.73	$194.13	$89.60	$116.48
☐ Two Person	$1,734.86	$1,105.74	$629.12	$290.36	$377.47
☐ Family	$2,168.57	$1,442.00	$726.57	$335.34	$435.94

HAP HMO Option 1	Premium	Hard Cap 2017	Monthly Employee Portion	Payroll deduct on 26 pays*	Payroll Deduct on 20 Pays*
☐ Single	$589.87	$528.73	$61.14	$28.22	$36.68
☐ Two Person	$1,415.68	$1,105.74	$309.93	$143.05	$185.96
☐ Family	$1,769.60	$1,442.00	$327.60	$151.20	$196.56

HAP HMO Option 8	Premium	Hard Cap 2017	Monthly Employee Portion	Payroll deduct on 26 pays*	Payroll Deduct on 20 Pays*
☐ Single	$514.92	$528.73	$0.00	$0.00	$0.00
☐ Two Person	$1,235.81	$1,105.74	$130.07	$60.03	$78.04
☐ Family	$1,544.77	$1,442.00	$102.77	$47.43	$61.66

HAP HMO Option 7 w/ Debit Card	Premium	Hard Cap 2017	Monthly Employee Portion	Payroll deduct on 26 pays*	Payroll Deduct on 20 Pays*
☐ Single	$419.95	$528.73	$0.00	$0.00	$0.00
☐ Two Person	$1,007.89	$1,105.74	$0.00	$0.00	$0.00
☐ Family	$1,259.86	$1,442.00	$0.00	$0.00	$0.00

Dental Plans – 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	$36.21		$0.00	$0.00	$0.00
☐ Two Person	$86.91		$0.00	$0.00	$0.00
☐ Family	$108.64		$0.00	$0.00	$0.00

***Employer determines payroll cycle**

2017 Benefit Enrollment Form

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	$4.84		$1.34	$0.81
☐ Two Person	$9.14		$3.01	$1.81
☐ Family	$12.90		$3.62	$2.17

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

Notes:____

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2017 Enrollment Form

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

☐ I am enrolling in the 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**

23033 Northline Road ● Taylor, Michigan 48180-4694 ● Telephone (734) 374-1200 ● Fax: 734-374-0375

I am waiving the following coverage for cash in lieu and I certify that I have been given the opportunity to enroll for group coverage offered by the Taylor School District.

______________ Medical coverage
Initial

______________ Dental coverage
Initial

______________ Vision coverage
Initial

I acknowledge and understand the following:

____
Initial
I cannot change my election until the next open enrollment period unless I experience certain family status changes recognized by the plan and I exercise my right to re-enroll within 30 days of my change in status.

____
Initial
I understand that if I decline coverage for myself and/or my spouse and dependents because of other health insurance coverage, I may be able to enroll myself, my spouse, or my dependents in the plan, if I request coverage within 30 days after my other coverage ends, and meet required guidelines including supplying documented proof of discontinuation of other coverage.

____
Initial
I understand that if I have a new dependent because of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents and myself within 30 days after the marriage, birth, adoption, or placement for adoption, if I meet required guidelines.

____
Initial
I understand that I must provide proof of other coverage by attaching a copy of my insurance card to this form in order to be eligible for the Taylor School District cash in lieu.

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Employee Name (Please Print)

______________________________ ____________________
Employee Signature Date

Benjamin Williams, Superintendent