2023 NEW HIRE & OPEN ENROLLMENT/WAIVER FORM

Please complete and return to Jane Rumsey.

Note: If you are a current employee, you only need to fill out your name.

First Name ______ Last Name ______ SSN ______

Street Address ______ Apt # ______ City ______ State ______ Zip Code ______

Home Phone ______ Email Address ______ Birthdate ______

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married

Hours worked per week ______

☐ **I waive all Medical, Dental, and Vision Coverage. (Sign page 2 and return.)**

☐ **I elect to maintain the same coverage as 2022 with no changes, at the 2023 rates. (Sign page 2 and return.)**

	Last Name	First Name	M.I.	Birthdate	SSN	Sex	Medical	Dental	Vision
EMPLOYEE							☐	☐	☐
SPOUSE							☐	☐	☐
CHILD							☐	☐	☐
CHILD							☐	☐	☐
CHILD							☐	☐	☐
CHILD							☐	☐	☐
CHILD							☐	☐	☐

PRE-TAX BENEFIT SELECTIONS: Check *Coverage* desired, calculate the cost and enter *Monthly Cost* the right hand column below:

Medical, Dental, and Vision Election & Monthly Employee Contribution: Coverage effective through 12/31/2023.						
Medical	BCBS of Michigan $250 / $500 - 100% **Gold**	☐ Employee-Only $114.07	☐ Two-Person $354.70	☐ Family $364.48	☐ Waive Coverage	$ ____ Monthly Cost
Medical	BCBS of Michigan $250 / $500 - 90% **Silver**	☐ Employee-Only $41.37	☐ Two-Person $191.11	☐ Family $160.90	☐ Waive Coverage	$ ____ Monthly Cost
Medical	BCBS of Michigan $1,000 / $2,000 - 80% **Bronze**	☐ Employee-Only $0.00	☐ Two-Person $10.90	☐ Family $0.00	☐ Waive Coverage	$ ____ Monthly Cost
Medical	BCBS of Michigan $1,500 / $3,000 - 100% **HSA***	☐ Employee-Only $0.00	☐ Two-Person $73.66	☐ Family $14.73	☐ Waive Coverage	$ ____ Monthly Cost
Dental	ASR Gold	☐ Employee-Only $33.34	☐ Two-Person $74.27	☐ Family $94.94	☐ Waive Coverage	$ ____ Monthly Cost
Dental	ASR Silver	☐ Employee-Only $0.00	☐ Two-Person $0.00	☐ Family $0.00	☐ Waive Coverage	$ ____ Monthly Cost
Vision	EyeMed	☐ Employee-Only $0.00	☐ Two-Person $0.00	☐ Family $0.00	☐ Waive Coverage	$ ____ Monthly Cost

HSA Direct Deposit: If electing the Health Savings Account option, complete the below section if you would like H.S.A. payroll deductions:

2022 Annual Maximum HSA contributions		
Coverage type	**Total annual contribution***	**Per month**
Self-only	$3,850	$320.83
Two-Person / Family	$7,500	$625.00

* Catch-up contribution (age 55+): additional $1,000 / year

CC: PAYROLL / EMPLOYEE FILE

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HSA Contribution Contribution Calculator		
Total annual contribution	Enter your desired contribution for the year: $______________ / 12 =	$____ Total Monthly Deduction

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of January 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

EMPLOYER PAID BENEFIT SELECTIONS: Check *Coverage* desired below:

Life Insurance Coverage – NIS	
☒ Employer Paid Life	N/A Monthly Cost

Please See NIS Options packet for voluntary options such as additional life and disability insurance.

Beneficiary(ies): Please name a beneficiary(ies) for your Life Insurance

First Name	MI	Last	Relationship	%	Primary or Secondary

Multiple beneficiaries will be considered equal unless designated as: Primary (1) or Secondary (2).
Note: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Please contact your personal tax advisor for further information.

Signature/Authorization - I have received and read all the materials explaining my options.

Dependents:

- I understand the rules that define who are eligible under the plan and I represent that the dependent(s) I am enrolling is/are eligible under the plan.
- I acknowledge that I may be asked to provide proof of my dependents' eligibility and I agree to provide proof, if requested.
- I agree to timely notify the plan if my dependent becomes ineligible for the plan.

Pre-Tax Contributions: I have read and understand the explanation I have received regarding my options under the group health plan. I hereby apply for the benefit options selected above, and I authorize my employer to withhold from my pretax compensation the total amount indicated to purchase the medical and/or dental coverage designated above for the Plan Year/ period of coverage **ending December, 2023**. I acknowledge that I cannot change or revoke this compensation reduction authorization at any time during the plan year unless certain changes in my status occur and only to the extent I request the change within 30 days of the event and the change in election is consistent with the change in status *(i.e.,* marriage, divorce, legal separation, birth or adoption of a child, death of a spouse or dependent, termination of employment of myself or my spouse, dependent no longer eligible).

Please check the following box if you do not want your medical/dental//HSA contributions to be taken on a pre-tax basis. ☐

I hereby certify that the statements herein are complete and accurate to the best of my knowledge. I understand that benefits may be affected if I knowingly provide false, incomplete, or misleading information on this form and that this action may result in further disciplinary action up to and including termination.

Signature:		Date:	