Name

Location

July 1, 2024-June 30, 2025 Plan Election and Premium Confirmation Form

The Local Choice MEDICAL INSURANCE (DENTAL & VISION INCLUDED)

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

☐ I decline Medical (along with Dental and Vision) coverage. ***Please check reason for declining coverage*** .

☐ On Spouse's Plan ☐ Medicare / Medicaid ☐ Don't want coverage

☐ On Individual Plan ☐ Healthcare.gov / Marketplace ☐ Military

☐ New Hire

Payroll Deductions (*per payroll*)		The Local Choice HDHP $3200/20%/5000		The Local Choice Key Advantage $1000/20%/5000	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

HealthEquity Health Savings Account (HSA) *Must make an election even if currently enrolled

☐ Employer AND Employee funded - please create an account for me. I understand I must complete carrier enrollment.

☐ I decline this account.

HealthEquity FLEXIBLE SPENDING ACCOUNT (FSA) *Must make an election even if currently enrolled

☐ 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

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