Benefit Election Form
Plan Year: 01.01.19 – 12.31.19

Thank you for your time and attention as you enroll for benefits with Pike County School Corporation. **Please complete this checklist, along with any necessary enrollment forms as listed below and return to Chelsea Yon by 5pm. on Friday, November 16, 2018.**

How to Make Benefit Elections

Step #1	Complete the benefit election form.
Step #2	Complete the necessary carrier forms (e.g. Anthem, VSP)
Step #3	Return all forms to Chelsea Yon

Employee Information

Employee Name: _____ **SSN:** _____

Address: _____

City: _____ **State:** _____

Zip: _____ **Gender:** ☐ Male | ☐ Female

Phone: _____

Date of Birth: _____ **Date of Hire:** _____

Dependent Information

Please indicate desired coverage for each dependent below.

	Name	DOB	SSN	Gender	Medical	Vision
Spouse:				☐ M | ☐ F	☐	☐
Child:				☐ M | ☐ F	☐	☐
Child:				☐ M | ☐ F	☐	☐
Child:				☐ M | ☐ F	☐	☐
Child:				☐ M | ☐ F	☐	☐
Child:				☐ M | ☐ F	☐	☐

Medical

☐	No Change – Maintain current plan enrollment/waiver for myself and any dependents enrolled
☐	Decline Coverage – New waiver (need to complete additional form)
☐	New Enrollment – Not currently enrolled in either (need to complete additional form)
☐	Change in Enrollment (need to complete additional form)

		HDHP Plan		Copay Plan
Employee Only	☐	$18.40	☐	$87.45
Employee + Family	☐	$41.81	☐	$230.68

Health Savings Account – Only for those who elect the HDHP medical option

☐	**Decline deduction**
☐	**New Deduction – (need to complete additional form)**

PAYROLL DEDUCTION BASED ON 24 PAYS PER YEAR		
$_____ Annually ($_____Per Pay)	**Maximum individual annual contribution:**	**$3,450 •**
I do not wish to contribute to an HSA ☐	**Maximum employee + child(ren):**	**$6,900 •**
	For Employees 55 years or older - add'l	**$1,000**

	If you are enrolling in the High Deductible Health Plan, a Health Savings Account information is available through Home Building Savings Bank.

• You may contribute toward your Health Savings Account. You are not eligible to contribute to a Health Savings Account if you are covered under a traditional health insurance plan, Medicare, or a military health insurance plan.

Vision

☐	Decline Coverage – New waiver (need to complete additional form)
☐	New Enrollment – Not currently enrolled in plan (need to complete additional form)
☐	Change in Enrollment (need to complete additional form)

		Per Pay Cost
Employee Only	☐	$4.22 per pay
Employee + Spouse	☐	$9.10 per pay
Employee + Child(ren)	☐	$7.36 per pay
Employee + Family	☐	$12.24 per pay
Decline Coverage	☐	

vsp Vision care for life	**If you are electing vision coverage for the first time or are adding dependents to your coverage, you must complete the enrollment form.**

Section 125

☐	I authorize Pike County School Corporation to make the above-mentioned payroll deductions on a **pre-tax** basis.
☐	Deductions for the above-mentioned elections should be made on a **post-tax** basis.

I understand that I cannot change or revoke this election at any time during the Plan Year unless I have a qualifying Life Event change (i.e. marriage, divorce, death, birth or adoption of a child, termination of spouse's coverage or employment). In addition, if I have declined coverage, I understand that I am not eligible again until the annual open enrollment, unless I have a change in family status or qualifying HIPAA event.

Employee Printed Name:	
Employee Signature:	
Date:	