



Section 1 – Employee Information *Please print information about yourself.*

Employee Name (Last, First, M.I.)	Date of Birth	Date of Hire	Social Security #	M/F	Address, City, State & Zip
Email Address		Phone		Location	
Please check the appropriate box: NEW HIRE <input type="checkbox"/> CURRENT EMPLOYEE - BENEFIT CHANGE <input type="checkbox"/>					

Section 2 –Spouse/ Dependent Information *Please include all covered dependents and their elections for 2024.*

***** Complete Below Only If You Are Electing to Cover or Remove Any Dependents*****

Full Name	SSN	Gender	Birthdate	Relationship	Medical	Dental	Vision
Spouse					<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term
Dep					<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term
Dep					<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term
Dep					<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term
Dep					<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term	<input type="checkbox"/> Enroll <input type="checkbox"/> Term

Section 3 – Benefits Selection *Please make your benefit selection in the following chart.*

MEDICAL & RX ELECTION - BCBSM			
	<i>Monthly Contributions</i>		
	<i>Single</i>	<i>2 Person</i>	<i>Family</i>
Blue Cross Blue Shield PPO	<input type="checkbox"/> \$169.38	<input type="checkbox"/> \$402.84	<input type="checkbox"/> \$503.97
<input type="checkbox"/> Decline Medical (Waive) – Must sign Medical Waiver in order to receive stipend-in-lieu			You receive \$2,400.00

OPT OUT ATTESTATION OF OTHER HEALTH INSURANCE COVERAGE

I choose to decline medical and prescription drug coverage offered by Eastpointe Community Schools. By signing below, I attest I understand that the Patient Protection and Affordable Care Act, also called Health Care Reform requires most individuals to have health insurance or pay a penalty for non-compliance. All members of my Tax Family have or will have other Group Health Coverage that is Minimum Essential Coverage for the entire plan year, January 1, 2024 through December 31, 2024. "Tax Family" includes you and all other individuals you reasonably expect to claim a personal exemption deduction for the taxable year or years covered by the opt-out time period. "Minimum Essential Coverage" is medical coverage that meets minimum standards under the Affordable Care Act. It does not include coverage purchased in the individual market, whether or not obtained through the Marketplace. I understand that I will have an opportunity to enroll for medical and prescription drug coverage during the next annual benefit enrollment period, or I may enroll for coverage before then if I qualify for a special enrollment period or have a qualifying change in status. I understand that to enroll for coverage during a special enrollment period or due to a qualifying change in status, I must request coverage from my employer within 30 days of the event. I understand that this Attestation is required annually to continue and I affirm the information I am providing is true and accurate to the best of my knowledge.

Signature:

Date:

DENTAL ELECTION – ADN

	<i>Monthly Contributions</i>		
	<i>Single</i>	<i>2 Person</i>	<i>Family</i>
<input type="checkbox"/> Dental Enrollment – Core Plan	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
<input type="checkbox"/> Dental Enrollment – Buy Up Plan	<input type="checkbox"/> \$29.60	<input type="checkbox"/> \$66.91	<input type="checkbox"/> \$80.31
<input type="checkbox"/> Decline Dental – Annual Opt Out Bonus	<input type="checkbox"/> You receive \$350.00 Annually		
<i>* If your spouse is an employee of the district, you will both be enrolled in the Buy-Down Plan and \$150 will be deposited into a HCRA for each employee.</i>			

VISION ELECTION – MetLife – All employees are enrolled in the Core Plan

<input type="checkbox"/> Vision Enrollment –Core Plan	<input type="checkbox"/> \$ 0.00	<input type="checkbox"/> \$ 0.00	<input type="checkbox"/> \$ 0.00
<input type="checkbox"/> Vision Enrollment –Buy Up Plan	<input type="checkbox"/> \$ 2.06	<input type="checkbox"/> \$ 3.91	<input type="checkbox"/> \$ 6.01

OPTIONAL LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT – MUTUAL OF OMAHA

If you are newly electing or increasing your coverage for 2024, evidence of insurability is required.

<p>Optional Life & AD&D Amount</p> <p><input type="checkbox"/> Employee Life Amount \$ _____</p> <p><input type="checkbox"/> Employee AD&D Amount \$ _____</p> <p><input type="checkbox"/> Spouse Life Amount \$ _____</p> <p><input type="checkbox"/> Spouse AD&D Amount \$ _____</p> <p><input type="checkbox"/> Dependent Life Amount \$ _____</p> <p><input type="checkbox"/> Dependent AD&D Amount \$ _____</p> <p><input type="checkbox"/> No Coverage</p> <p>Note: Employee must enroll in coverage if electing spouse/dependent coverage.</p> <p>\$ _____ /\$1,000 X \$ _____ = \$ _____</p> <p>Optional Life + AD&D Amount Rate Cost per month</p> <p>Calculate your monthly cost by dividing selection by 1,000 X rate in chart to right</p>	<p align="center">Monthly Rate Per \$1,000 of coverage Employee/Spouse</p> <table border="1"> <thead> <tr> <th>Age</th> <th>Life Rate</th> <th>AD&D Rate</th> </tr> </thead> <tbody> <tr><td>Under 25</td><td>\$0.070</td><td>\$0.025</td></tr> <tr><td>25 - 29</td><td>\$0.070</td><td>\$0.025</td></tr> <tr><td>30 - 34</td><td>\$0.090</td><td>\$0.025</td></tr> <tr><td>35 - 39</td><td>\$0.090</td><td>\$0.025</td></tr> <tr><td>40 - 44</td><td>\$0.140</td><td>\$0.025</td></tr> <tr><td>45 - 49</td><td>\$0.210</td><td>\$0.025</td></tr> <tr><td>50 - 54</td><td>\$0.340</td><td>\$0.025</td></tr> <tr><td>55 - 59</td><td>\$0.510</td><td>\$0.025</td></tr> <tr><td>60 - 64</td><td>\$0.580</td><td>\$0.025</td></tr> <tr><td>65 - 69</td><td>\$0.960</td><td>\$0.025</td></tr> <tr><td>70+</td><td>\$1.68</td><td>\$0.025</td></tr> </tbody> </table> <p>Dependent child(ren) rate is \$0.11 for Voluntary Life and \$0.040 for Voluntary AD&D per \$1,000 of coverage</p>	Age	Life Rate	AD&D Rate	Under 25	\$0.070	\$0.025	25 - 29	\$0.070	\$0.025	30 - 34	\$0.090	\$0.025	35 - 39	\$0.090	\$0.025	40 - 44	\$0.140	\$0.025	45 - 49	\$0.210	\$0.025	50 - 54	\$0.340	\$0.025	55 - 59	\$0.510	\$0.025	60 - 64	\$0.580	\$0.025	65 - 69	\$0.960	\$0.025	70+	\$1.68	\$0.025
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MUTUAL OF OMAHA BENEFICIARY INFORMATION

Name (Last, First, M.I.)	Date of Birth	Social Security Number	Gender	Relationship	Primary / Secondary	
					<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary
Address, City, State, Zip				Phone Number		
Name (Last, First, M.I.)	Date of Birth	Social Security Number	Gender	Relationship	Primary / Secondary	
					<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary
Address, City, State, Zip				Phone Number		

FLEXIBLE SPENDING ACCOUNT- EBC

<input type="checkbox"/> Health Care Reimbursement Account You may elect up to \$3,200 annually (minimum \$60)	Annual Election: \$ _____
<input type="checkbox"/> Dependent Care Reimbursement Account You may elect up to \$5,000 annually or \$2,500 annually if married filing separate tax returns (minimum \$60)	Annual Election: \$ _____

ACKNOWLEDGEMENT – PLEASE SIGN BELOW

I have reviewed the terms of Eastpointe Community Schools Cafeteria Plan (“the Plan”). I understand that I may elect coverage for the period beginning January 1, 2024 and ending December 31, 2024.

ELECTION OF BENEFITS

- I elect to pay my required contributions for health coverage on a pre-tax basis under Eastpointe Community Schools Cafeteria Plan. I understand my salary will be reduced by an equal amount each pay period to cover the cost of my required contributions during the plan year. This election replaces any prior election(s) I have made.
- I have been provided with a schedule of required contributions.
- I understand that except for a Change in Status for the applicable coverage under the Plan, I cannot change my benefits election until the next Annual Enrollment period.

AGREEMENT

I agree that my salary will be reduced by the amount of my required contribution for health benefits I have selected under the Plan, and that salary reductions will continue for each pay period until this election is changed or terminated. I understand that:

- I cannot change or revoke my election prior to the next Annual Enrollment period, unless I experience a Change in Status as defined in the Plan (e.g., birth of a child, divorce, marriage, etc.), and my election change (or revocation) is on account of and is consistent with the Change in Status, as described in the Plan.
- I must complete any separate health insurance enrollment form(s) provided by the insurer(s).
- Under current law salary reduction contributions are not counted when determining FICA earnings. If an employee earns less than the Social Security base wage, his/her eventual Social Security benefits could be slightly reduced. The value of income and FICA tax savings will normally exceed any eventual reduction in Social Security benefits.

Each year during the Annual Enrollment period, I will have an opportunity to change my election. If I do not complete and return a new Salary Reduction Agreement at that time, this election will continue unchanged until I make a new election under the terms of the Plan.

I have read and agree to the terms in this Agreement and in the Eastpointe Community Schools Cafeteria Plan.

Signature:

Date:

OFFICE USE ONLY

DATE OF EVENT: _____

TYPE OF ENROLLMENT:

- NEW REHIRE FULLTIME PART TIME OPEN ENROLLMENT SPECIAL OPEN ENROLLMENT LOSS OF COVERAGE MARRIAGE COBRA
 DIVORCE FULLTIME RETIRED DEATH RET/RESIGNATION DEP OVERAGE MARRIAGE OTHER:

SYSTEM CHANGES:

- BCBS ADN METLIFE MOO AS400

ADDITIONAL TASKS:

- INIITAL GENERAL NOTICE COBRA LETTER COBRA NOTIFICATION LETTER

Return this completed form to Human Resources, Eastpointe Community Schools 24685 Kelly Road, Eastpointe MI 48021