EASTPOINTE COMMUNITY SCHOOLS

2024 Election Form – Local 120 Head Cooks

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 ☐ CURRENT EMPLOYEE - BENEFIT CHANGE ☐

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					☐ Enroll ☐ Term	☐ Enroll ☐ Term	☐ Enroll ☐ Term
Dep					☐ Enroll ☐ Term	☐ Enroll ☐ Term	☐ Enroll ☐ Term
Dep					☐ Enroll ☐ Term	☐ Enroll ☐ Term	☐ Enroll ☐ Term
Dep					☐ Enroll ☐ Term	☐ Enroll ☐ Term	☐ Enroll ☐ Term
Dep					☐ Enroll ☐ Term	☐ Enroll ☐ Term	☐ Enroll ☐ Term

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

MEDICAL & RX ELECTION - BCBSM

	Monthly Contributions		
	Single	***2 Person***	***Family***
Blue Cross Blue Shield PPO	☐ $168.37	☐ $400.45	☐ $500.99

☐ Decline Medical (Waive) – Must sign Medical Waiver in order to receive stipend-in-lieu

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

	Monthly Contributions		
	Single	***2 Person***	***Family***
☐ Dental Enrollment – Core Plan	☐ $0.00	☐ $0.00	☐ $0.00
☐ Dental Enrollment – Buy Up Plan	☐ $29.60	☐ $66.91	☐ $80.31

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

☐ Vision Enrollment –Core Plan	☐ $1.78	☐ $1.78	☐ $1.78
☐ Vision Enrollment –Buy Up Plan	☐ $3.78	☐ $5.58	☐ $7.62

Dental Note: If your spouse is an employee of the district, you will both be enrolled in the Buy-Down Plan.

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.

Optional Life & AD&D Amount

- ☐ Employee Life Amount $_____
- ☐ Employee AD&D Amount $ _____
- ☐ Spouse Life Amount $_____
- ☐ Spouse AD&D Amount $_____
- ☐ Dependent Life Amount $_____
- ☐ Dependent AD&D Amount $_____
- ☐ No Coverage

Note: Employee must enroll in coverage if electing spouse/dependent coverage.

$_____ /$1,000 X $ _____ = $_____

Optional Life + AD&D Amount Rate Cost per month

Calculate your monthly cost by dividing selection by 1,000 X rate in chart to right

Monthly Rate Per $1,000 of coverage Employee/Spouse

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

Dependent child(ren) rate is $0.11 for Voluntary Life and $0.040 for Voluntary AD&D per $1,000 of coverage

MUTUAL OF OMAHA BENEFICIARY INFORMATION

Name (Last, First, M.I.)	Date of Birth	Social Security Number	Gender	Relationship	Primary / Secondary	
					☐ Primary	☐ Secondary
Address, City, State, Zip				**Phone Number**		

Name (Last, First, M.I.)	Date of Birth	Social Security Number	Gender	Relationship	Primary / Secondary	
					☐ Primary	☐ Secondary
Address, City, State, Zip				**Phone Number**		

FLEXIBLE SPENDING ACCOUNT- EBC

☐ Health Care Reimbursement Account You may elect up to $3,200 annually (minimum $60)	Annual Election: $_____
☐ 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: $_____

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

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

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