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

|  |  |
| --- | --- |
| **Employee Name (Last, First, M.I.)** | **Address, City, State & Zip** |
|  |  |
| **Date of Birth** | **Date of Hire** | **Social Security Number** | **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 2025.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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)  |

|  |
| --- |
| **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, 2025 through December 31, 2025. “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:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

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| **DENTAL ELECTION - ADN** |
|  | ***Monthly Contributions*** |
|  | ***Single*** | ***2 Person*** | ***Family*** |
| □ Dental Enrollment – Core Plan□ Dental Enrollment – Buy Up Plan | * $0.00
* $8.15
 | * $0.00
* $17.51
 | * $0.00
* $24.79
 |
| **VISION ELECTION – NVA – All employees are enrolled in the Core Plan** |
| □ Vision Enrollment –Core Plan□ Vision Enrollment –Buy Up Plan | * $1.78
* $3.85
 | * $1.78
* $5.71
 | * $1.78
* $7.81
 |

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| **OPTIONAL LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT – MUTUAL OF OMAHA** |
| If you are newly electing or increasing your coverage for 2025, 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 monthCalculate 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 $0.025Dependent 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 ofBirth** | **Social Security Number** | **Gender** | **Relationship** | **Primary / Secondary** |
|  |  |  |  |  | * Primary
 | * Secondary
 |
| **Address, City, State, Zip** | **Phone Number** |
|  |  |
| **Name (Last, First, M.I.)** | **Date ofBirth** | **Social Security Number** | **Gender** | **Relationship** | **Primary / Secondary** |
|  |  |  |  |  | * Primary
 | * Secondary
 |
| **Address, City, State, Zip** | **Phone Number** |
|  |   |

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| **FLEXIBLE SPENDING ACCOUNT- CORNERSTONE** |
| * Health Care Reimbursement AccountYou may elect up to $3,300 annually (minimum $60)
 | Annual Election:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Dependent Care Reimbursement AccountYou may elect up to $5,000 annually or $2,500 annually if married filing separate tax returns (minimum $60)
 | Annual Election:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
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| **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, 2025 and ending December 31, 2025.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.

AGREEMENTI 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  NVA  MOO  AS400

**Additional Tasks:**

 Iniital general notice cobra letter  cobra notification letter