HEALTH INSURANCE ELECTION FORM - PLAN YEAR AUGUST 1, 2017 - JULY 31, 2018

FULL NAME: ***SSN or EE ID #*** ***New*** ☐ ***Change*** ☐

EFFECTIVE DATE:_____ ***Retro*** ☐ ***From Plan*** ***To Plan or New***

EMPLOYEE BENEFIT ELECTIONS

MEDICAL ELECTION

Anthem BlueCross BlueShield

Medical Plan Selections Are For Medical Coverage Only

All Rates Are Monthly / Active Employee Rates

Plan Selection:	***Coverage Level Selection:*** Employee Only	Employee + 1 Child	Employee + Spouse	Employee + Family	***PREMIUM CONVERSION***
☐ Lumenos Plan	☐ $0.00	☐ $158.00	☐ $221.00	☐ $288.00	☐ Elect
☐ HealthKeepers Plan	☐ $43.00	☐ $280.00	☐ $394.00	☐ $515.00	☐ Do Not Elect
☐ Keycare Plan	☐ $166.00	☐ $460.00	☐ $642.00	☐ $850.00	
☐ *No Medical Coverage					

***Notice of Intent to Decline Form is Required if No Medical is Checked**

DENTAL ELECTION

EFFECTIVE DATE:_____ ***Retro*** ☐ ***From Plan*** ***To Plan or New***

DELTA DENTAL

Dental Plan Selections Are For Dental Coverage Only

All Rates Are Monthly / Active Employee Rates

Plan Selection:	***Coverage Level Selection:*** Employee Only	Employee + 1 Child	Employee + Spouse	Employee + Family	***PREMIUM CONVERSION***
☐ Dental Coverage	☐ $9.00	☐ $12.00	☐ $14.00	☐ $18.00	☐ Elect
☐ No Dental Coverage					☐ Do Not Elect

SUBSCRIBER'S SIGNATURE

I have indicated my benefit elections above. I understand that I cannot change my elections during the plan year, unless I have a **Change In Status** (family or employment status - i.e.: marriage, divorce, birth, etc). I agree to pay the amount of my required contributions as indicated in the above elections either **before-tax** (**Elect Premium Conversion**), or after- tax, as applicable.

SIGNATURE **DATE**

TO BE COMPLETED BY HUMAN RESOURCES

SIGNATURE **DATE**

TO BE COMPLETED BY PAYROLL

CBH _____ **Social Services** _____ **Monthly** _____ **Bi-Weekly** _____

Employee # _____ **G/L Code** _____

EE AMOUNT	ER AMOUNT	DEDUCTION CODE
From:_____	**From:**_____	**From:**_____
To:_____	**To:**_____	**To:**_____

SIGNATURE **DATE**