EMPLOYEE SOLUTIONS GROUP

Employee Benefit Election Form

City of Benson
Effective date: July 1st, 2024
1st Payroll Date: July 5th, 2024

Last Name, First, Middle		Social Security Number - -		Date of Birth / /
Mailing Address		City	State	Zip
Email	Mobile Alerts provide mobile number ( )	Date of Birth / /	Hours/week	Home Phone Number ( )

Select all that apply: July 1st, 2024 to June 30th, 2025

AETNA MEDICAL PLAN: (all payroll deductions receive pretax status) ☐ Waive Coverage / Reason _____

☐ **Aetna PPO Plan:** ☐ Employee Only ($0) ☐ Employee/Spouse ($110.25) ☐ Employee/Child(ren) ($72.63) ☐ Family ($160.42)

☐ **Aetna HSA Plan:** ☐ Employee Only ($0) ☐ Employee/Spouse ($96.74) ☐ Employee/Child(ren) ($63.66) ☐ Family ($140.85)

AETNA DENTAL PLAN: (all payroll deductions receive pretax status) ☐ Waive Coverage / Reason _____

☐ **Aetna Dental Plan** ☐ Employee Only ($12.75) ☐ Employee/Spouse ($25.40) ☐ Employee/ Child(ren) ($36.55) ☐ Family ($49.20)

PRINCIPAL DENTAL PLAN: (all payroll deductions receive pretax status) ☐ Waive Coverage / Reason _____

☐ **Principal Dental Plan** ☐ Employee Only ($16.11) ☐ Employee/Spouse ($33.50) ☐ Employee/ Child(ren) ($39.25) ☐ Family ($59.41)

VSP VISION PLAN: (all payroll deductions receive pretax status). ☐ Waive Coverage / Reason _____

☐ **VSP Vision Plan:** ☐ Employee Only ($3.69) ☐ Employee/Spouse ($5.90) ☐ Employee/Child(ren) ($6.03) ☐ Family ($9.72)

PRINCIPAL BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT PLAN: I acknowledge if I reach and maintain my eligibility, I am authorized to participate in the Basic Life ($20,000) and Accidental Death & Dismemberment plan which is paid 100% by my employer.

☐ I am requesting to purchase additional supplemental life coverage that will be offered at my expense. Rates are dependent on age and completion of a short questionnaire and may be denied by the carrier based on these responses.

HSA VOLUNTARY CONTRIBUTIONS TO MY HSA BANK ACCOUNT: (all payroll deductions receive pretax status)

☐ I am electing additional contributions to my HSA Bank Account beyond the amounts contributed by my employer. This election will be made over the next 24 payrolls in equal installments on a pretax basis thru payroll deductions.

SUPPLEMENT HSA CONTRIBUTION $_____ Per Plan Year (OVER age 55 are eligible for catch up contributions)	Maximum annual election for Single insured is $4,150 Maximum annual election for Family insured is $8,300 Catch Up Contributions are limited to $1,000 per eligible account

FSA VOLUNTARY CONTRIBUTIONS TO MY FSA SAVINGS ACCOUNT: (all payroll deductions receive pretax status)

☐ I am electing contributions to my FSA Account. This election will be made over the next 24 payrolls on a pretax basis thru payroll deductions.

MEDICAL FSA CONTRIBUTION: (Annual) $_____ **DEPENDENT DAY CARE CONTRIBUTION: (Annual)** $_____ Dependent #1:_____ DOB _____ ☐ Male ☐ Female Dependent #2:_____ DOB _____ ☐ Male ☐ Female	**Medical FSA** election is a maximum of $3,200 per employee and/or family. In the event you elect to participate in the HSA plan and make contributions to an HSA bank account, the FSA election is eligible for dental and vision expenses only. **Limited Purpose FSA** election is available for members that elect the HSA plan and/or funding arrangement by the employer. Limited Purpose FSA eligible expenses include on dental and vision expenses. **Dependent Day Care** maximum election annually of $5,000.

AUTHORIZATION TO EXECUTE MY ELECTIONS: I authorize my Employer, to make salary reductions for my share of the costs as published in the benefit rollout memorandum on a pretax basis. I understand that my election will remain in place for the entire plan year and may only be modified under special life status changes authorized by the Internal Revenue Service. If a change is required, seek advice from your plan administrator. **DIRECT DEPOSIT AUTHORIZATION:** I authorize ESG to utilize my bank account to reimburse my manual claims. **SALARY REDUCTION AUTHORIZATION:** I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire Plan year and cannot be changed or revoked except as permitted by federal law.

DIRECT DEPOSIT BANK AUTHORIZATION	
BANK NAME:	☐ **CHECKING ACCOUNT** ☐ **SAVINGS ACCOUNT**
Transit/ABA Routing #:	**Account #:**

This authority is to remain in full force and effect until ESG has received written notification from me of its termination in such time and manner as to afford ESG or my Financial Institution a reasonable opportunity to act on it. You must notify ESG within 7 days of any deposit errors or missing deposits. In the event no direct deposit information is provided and a replacement check is issued, a service fee will be charged. I authorize my EMPLOYER AND/OR TPA to intervene on my behalf using personnel data to update or amend the DEPOSITORY ACCOUNTS when information could not be validated as submitted. I authorize the Depository, Healthcare Bank, as Custodian of my HSA, to provide my HSA balance to the Third-Party Administrator (ESG). Account balance information will be confidential and may be accessed by the TPA for servicing my account when authorized by me. I further authorize DEPOSITORY to notify myself, my EMPLOYER AND/OR TPA if an ACH Deposit fails verification of identity. I understand that HSA enrollment is subject to DEPOSITORY approval. HSA Participant Agreement is to remain in full force and effect until EMPLOYER AND/OR TPA has received written termination and transfer of available funds. In the event of an error or omission, ESG will notify and remedy the error or omission within a reasonable period of time. The employer and employee agree to ESG's procedures for making any corrections, including but not limited to adjusting payroll deduction. An error by the employer or ESG does not constitute an assumption of liability for the amount of the error.

PARTICIPANT SIGNATURE	**DATE**

Name (first, middle initial, last)		**SS #**	**Name (first, middle initial, last)**		**SS #**
Spouse:	DOB:		Child:	DOB:	
Child:	DOB:		Child:	DOB:	
Child:	DOB:		Child:	DOB:	