FY 22/23 BENEFITS OPEN ENROLLMENT CHANGE FORM FOR HEALTH, DENTAL, OR VISION

COMPLETE THIS FORM IF YOU WANT TO MAKE CHANGES TO ANY OF YOUR BENEFITS AND RETURN TO HUMAN RESOURCES BY APRIL 23, 2022. EVERYONE MUST SIGN AND RETURN THEIR BENEFITS STATEMENT FORM TO THEIR DESIGNATED HUMAN RESOURCES REPRESENTATIVE (THIS LIST IS LOCATED ON THE EMPLOYEE COMMUNICATIONS EMAIL) AND IF YOU HAVE CHANGES AN OPEN ENROLLMENT CHANGE FORM MUST ALSO BE SUBMITTED.

EMPLOYEE INFORMATION … PLEASE PRINT CLEARLY

EMPLOYEE #:	NAME (FIRST NAME, MI, LAST NAME):				
ADDRESS:					
SS#:	DATE OF BIRTH:	MARITAL STATUS: SINGLE	☐	MARRIED	☐

HEALTH, DENTAL AND VISION INSURANCE ELECTIONS …

Spouses may be covered ONLY if their current Employer does NOT offer coverage OR if they are unemployed with NO other coverage AND you MUST complete a Spouse Employment Affidavit Form. If you are ADDING Dependents, you MUST provide Verification Documents of having Legal Custody. Forms can be located on Employee Self Service > Benefits Information > Open Enrollment 2022-2023 or go to your Open Enrollment Email and click on the link.

TYPE OF COVERAGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD	EMPLOYEE + CHILDREN	EMPLOYEE + FAMILY	OPT-OUT/WAIVE COVERAGE
MEDICAL	☐ PPO BASE ☐ HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HSA ☐ PPO BUY-UP	WITH $2,000 HRA REIMBURSEMENT ☐ WITH NO HRA REIMBURSEMENT ☐ ***You must provide proof of other coverge to elect this plan***
DENTAL	☐ LOW PLAN ☐ HIGH PLAN	☐ LOW PLAN ☐ HIGH PLAN		☐ LOW PLAN ☐ HIGH PLAN	☐ LOW PLAN ☐ HIGH PLAN	Initial in this Box to WAIVE Dental Coverage ☐
VISION	☐ COMPREHENSIVE ☐ EYEWEAR ONLY	☐ COMPREHENSIVE ☐ EYEWEAR ONLY		☐ COMPREHENSIVE ☐ EYEWEAR ONLY	☐ COMPREHENSIVE ☐ EYEWEAR ONLY	Initial in this Box to WAIVE Vision Coverage ☐

Complete this section for a Spouse OR any Child(ren) you are covering on your Medical, Dental, and/or Vision . . .

COVERED DEPENDENTS	FIRST NAME MIDDLE INITIAL LAST NAME	SOCIAL SECURITY # *XXX-XX-XXXX*	DATE OF BIRTH *XX/XX/XXXX*	GENDER *MALE / FEMALE*	COVERAGE ELECTED (Please note Add or Drop in the blocks below)		
					MEDICAL	DENTAL	VISION
SPOUSE:							
CHILD:							
CHILD:							
CHILD:							

***** PLEASE LIST ADDITIONAL CHILD(REN) ON A SEPARATE SHEET OF PAPER "IF" NEEDED *****

HEALTH SAVINGS / FLEXIBLE SPENDING / DEPENDENT CARE ACCOUNTS

Complete this section if you want to have additional money payroll deducted into your Health Savings Account (HSA), Flexible Spending Account (FSA), OR Dependent Care Account . . . If you want to continue contributing to any of these for the upcoming year.

You MUST elect the HSA Plan above in order to contribute to a Health Savings Account (HSA). You MUST elect either the PPO Plan, the PPO Buy-Up Plan, or the Opt-Out Plan above in order to contribute to the Flexible Spending Account (FSA) and/or Dependent Care Account.

HEALTH SAVINGS ACCOUNT (HSA):

For HSA participants ONLY … list any additional money you would like payroll deducted into your Health Savings Account (HSA).
MAXIMUM ANNUAL CONTRIBUTIONS ALLOWED IS: $3,650 INDIVIDUAL/$7,300 FAMILY

PAY PERIOD ELECTION: $ _____ ANNUAL ELECTION: $ _____
(PERIOD ELECTIONS X'S 24 PAY PERIODS)

FLEXIBLE SPENDING ACCOUNT (FSA):

For PPO and PPO Buy-Up participants ONLY … list any additional money you would like payroll deducted into your Flexible Spending Account (FSA).
MAXIMUM ANNUAL CONTRIBUTIONS ALLOWED IS: $2,750

PAY PERIOD ELECTION: $ _____ ANNUAL ELECTION: $ _____
(PERIOD ELECTIONS X'S 24 PAY PERIODS)

DEPENDENT CARE (FSA):

MAXIMUM ANNUAL CONTRIBUTIONS ALLOWED IS: $5,000

PAY PERIOD ELECTION: $ _____ ANNUAL ELECTION: $ _____
(PERIOD ELECTIONS X'S 24 PAY PERIODS)

Sign here to WAIVE HSA, Flexible Spending, Dependent Care contributions: _____