Enrollment/Waiver Form

Plan Year: **01-01-22 thru 12-31-22**

For Office Use Only:	Effective Date:	Date of First Deduction:	Processed By:	Date:	Annual Earnings:

Employee Name: _____ ___Male ___Female **DOB:** ____/____/____ **SS#**_____

Street Address: _____ **City**_____ **State**_____

Zip Code_____ **County:** _____ **Home Phone:** (_____) _____

Email: _____ **Date of Full-Time Employment** _____/_____/_____ **Occupation:** _____

Marital Status: ___ Single ___Married ___ Widowed ___Divorced ___Legally Separated **Number of Hours worked per week:** _____

Insurance Premiums

I have elected the appropriate coverage(s) listed below and agree to the following insurance premium deduction per pay period through:

☐ **Post-Tax reduction of your salary (allows changes during the year)** ☐ **Pre-Tax reduction of your salary ***

*** If you select Pre-Tax, you cannot make election changes until next December**

CHOOSE YOUR MEDICAL COVERAGES - Each plan can be elected stand-alone or you may elect multiple plans depending on your needs – electing the MEC plan avoids the individual mandate penalty. **Kemper Benefits, Group# KB20527 / Anthem BCBS Group #W42910**

	MEC	Limited Medical	Drug Plan	Anthem $4900 deductible *(only available to those working 30+ hours/week)*
Single	☐ $8.68	☐ $9.27	☐ $7.08	☐ 9.61% of your weekly pay not to exceed $87.72/week
Employee + Spouse	☐ $11.68	☐ $15.51	☐ $13.63	☐ Above single cost plus $140.12/week
Employee + Child(ren)	☐ $10.52	☐ $14.80	☐ $12.04	☐ Above single cost plus $80.47/week
Family	☐ $13.98	☐ $21.23	☐ $19.30	☐ Above single cost plus $244.11/week
☐ **I Waive this coverage**			☐ **I Waive medical coverage for dependents only**	

If you are waiving coverage, are you covered under another medical plan? ____ Yes ____ No
If you are waiving dependent coverage, are your dependents covered under another medical plan? ____ Yes ____ No

HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION AUTHORIZATION

I authorize the reduction of my salary on a per paycheck basis, by the amount designated below. I understand that deductions cannot be remitted to my Health Savings Account until I have completed the HSA application and the account has been opened by the Bank.

Per Pay Period: $ _____ Annual Amount: $ _____

The IRS has established annual limits that can be contributed to Health Savings Accounts. The maximum amount can be deposited into your account in the 2022 calendar year is $3,650 for single coverage and $7,300 for family coverage. The catch-up provision for participants age 55 and older is $1000.

CHOOSE YOUR DENTAL COVERAGE (Check Plan type and one coverage box only)	**Kemper Benefits. Group# KB20527**
☐ Single	$3.20
☐ Employee + Spouse	$6.40
☐ Employee + Child(ren)	$7.01
☐ Family	$10.21
☐ **I Waive this coverage** ☐ **I Waive dental coverage for dependents only**	

CHOOSE YOUR VISION COVERAGE (Check Plan type and one coverage box only)	**Kemper Benefits. Group# KB20527**
☐ Single	$1.53
☐ Employee + Spouse	$2.90
☐ Employee + Child(ren)	$3.16
☐ Family	$4.06
☐ **I Waive this coverage** ☐ **I Waive dental coverage for dependents only**	

CHOOSE YOUR SHORT TERM DISABILITY COVERAGE (Check one coverage box only)		Kemper Benefits. Group# KB20527
Weekly Benefit: 60% of salary to a maximum of $150	☐ Age 18 - 49	$4.40
7 day waiting period / 26 week benefit duration	☐ Age 50 - 59	$4.98
	☐ Age 60 - 64	$5.91
	☐ **I waive this benefit**	

CHOOSE YOUR ACCIDENT EXPENSE COVERGE (Check one coverage box only)		Kemper Benefits. Group# KB20527
	$1,000 benefit	**$5,000 Benefit**
Single	☐ $1.86	☐ $4.97
Employee + Spouse	☐ $3.71	☐ $10.06
Employee + Child(ren)	☐ $4.51	☐ $12.70
Family	☐ $6.52	☐ $18.57
	☐ **I waive this benefit**	

Please complete if you are enrolling your spouse and/or children in any plan:

					Add (A), Change (C), Deletion (D)			
Dependents to be insured: (last name if different)	**Relationship (Spouse/Child)**	**M/F**	**Social Security #**	**DOB**	**Medical**	**Dental**	**Vision**	**Accident**

With regards to my salary redirections agreement and my election of benefits, I understand that:

If I elected a pre-tax deduction, I may not change elections during the plan year unless there is a change in my family status (i.e. marriage, divorce, death of my spouse or child, adoptions or birth of my child, change in job status of myself/spouse/dependent (full/part time, termination/beginning of employment), my dependents no longer eligible for insurance coverage, or a legal separation/annulment). I UNDERSTAND THAT I HAVE 30 DAYS FROM THE DATE OF ONE OF THE ABOVE OCCURRENCES TO MAKE A CHANGE IN MY PLAN. I understand that these elections do not constitute guaranteed coverage for any of the insurance listed nor does the cafeteria plan dates listed have any correlations to the effective date of insurance coverage. The administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for the benefits that are insured.

Other Health Coverage / Medicare Please check one: ____ YES ____ NO			
On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage /Medicare.			
Provide name, phone number and address of the HMO or insurance company		**Policy/Certificate Number**	**Effective Date** _____/_____/_____
Policy/Certificate holder's name	**Social Security Number** - -	**Date of Birth** _____/_____/_____	Relationship to Applicant

Printed Name: _____

Applicant Signature: _____ **Date:** _____/_____/_____