2025 Medical & Dental Health Plan Election – Active

Employee Name:_____ **EE#**_____ **Effective date:**_____

Reason for change: NEW HIRE **Dept#**_____ **Date sent to Payroll:**_____

Medical Insurance: (Please type **X** next to only one medical option or decline coverage)

IF YOU WOULD LIKE YOUR DEDUCTION TO BE "AFTER TAX" PLEASE TALK WITH THE INSURANCE REP IN HUMAN RESOURCES

Plan B	BROAD	Monthly	Pre-tax		Plan B	MEMORIAL	Monthly	Pre-tax		Plan B	KELSEY	Monthly	Pre-tax	
2964	Employee Only	$80.00	_____	(2066)	2971	Employee Only	$55.00	_____	(1700)	2971	Employee Only	$55.00	_____	(1704)
2965	Employee+Spouse	$235.00	_____	(2068)	2972	Employee+Spouse	$192.50	_____	(1701)	2972	Employee+Spouse	$192.50	_____	(1705)
2966	Employee+Child(ren)	$174.00	_____	(2067)	2973	Employee+Child(ren)	$143.00	_____	(1702)	2973	Employee+Child(ren)	$143.00	_____	(1706)
2967	Employee+Family	$328.00	_____	(2069)	2974	Employee+Family	$269.50	_____	(1703)	2974	Employee+Family	$269.50	_____	(1707)

Plan C	BROAD	Monthly	Pre-tax		Plan C	MEMORIAL	Monthly	Pre-tax		Plan C	KELSEY	Monthly	Pre-tax	
2955	Employee Only	$30.00	_____	(2170)	2975	Employee Only	$15.00	_____	(1708)	2975	Employee Only	$15.00	_____	(1712)
2956	Employee+Spouse	$105.00	_____	(2171)	2976	Employee+Spouse	$53.00	_____	(1709)	2976	Employee+Spouse	$53.00	_____	(1713)
2957	Employee+Child(ren)	$78.00	_____	(2172)	2977	Employee+Child(ren)	$39.00	_____	(1710)	2977	Employee+Child(ren)	$39.00	_____	(1714)
2958	Employee+Family	$147.00	_____	(2173)	2978	Employee+Family	$74.00	_____	(1711)	2978	Employee+Family	$74.00	_____	(1715)

Decline medical coverage:_____

All Dental and Vision Deductions are Monthly Amounts

Dental Insurance: AETNA (Please type **X** next to only one dental and vision option or decline coverage)

DMO	Monthly	Pre-tax		DPPO	Monthly	Pre-tax	
Employee Only	$0.23	_____	(2414)	Employee Only	$9.32	_____	(2426)
Employee+Spouse	$8.03	_____	(2043)	Employee+Spouse	$40.75	_____	(2052)
Employee+Child(ren)	$8.90	_____	(2042)	Employee+Child(ren)	$40.43	_____	(2051)
Employee+Family	$18.43	_____	(2044)	Employee+Family	$66.92	_____	(2053)

Decline dental coverag:_____

Vision Insurance: METLIFE

PPO Vision			
Employee Only	$8.33	_____	(2435)
Employee+Spouse	$16.68	_____	(2436)
Employee+Child(ren)	$17.17	_____	(2437)
Employee+Family	$23.77	_____	(2438)

Decline vision coverage:_____

I hereby authorize the above amounts to be deducted from my pay. A Personal Health Assessment (PHA) must be completed to pay the premiums shown on this form.

Failure to complete a PHA before December 27, 2024 will result in an additional fee of $50 per month for employee only or employee and child(ren) coverage, and $100 fee per month for employee and spouse coverage.

By signing this form, I declare that I have read and understood these terms.

Signature:_____ Date:_____

2025 Flex, Life and AD&D Election – Active

Employee Name: _____ **EE#** _____ **Effective date:** _____

Reason for change: NEW HIRE **Dept#** _____ **Date sent to Payroll** _____

Flexible Spending Accounts **Medical (1015)** **$**_____**/yr** **$**_____**Biweekly** **Dependent Care (1016)** **$** _____**/yr** **$**_____**Biweekly**

To determine Biweekly: Divide yearly by number of payrolls left in plan year **(Max Medical = $3,200 / yearly)** **(Max dependent Care = $5000 / yearly)**

Decline_____

(Please type the same coverage amount next to Additional Life and AD&D or decline coverage)

Voluntary Life Insurance: GRP # 306922 **Employee's Birthdate:**_____ **Age on 01/01/2025:** _____

Decline_____	**Coverage**	**Rate**	**B/W Ded Amount**
(2667) Employee Additional Life Insurance		**X**	$
(2668) Employee (AD&D)		**X** 0.0100	$
(2669) Spouse Life Insurance		**X**	$
(2670) Spouse (AD&D)		**X** 0.0175	$
(2671) Child/Children Life Insurance		**X** 0.1255	$
(2672) Child/Children (AD&D)		**X** 0.0175	$

Life Insurance Rates (24x)

Age		**Rate**
<24		**0.0250**
25-29		**0.0350**
30-34		**0.0350**
35-39		**0.0525**
40-44		**0.0725**
45-49		**0.0975**
50-54		**0.1780**
55-59		**0.2990**
60-64		**0.4450**
65-69	**65%**	**0.7600**
70-74	**50%**	**1.4750**
75+	**50%**	**2.9800**

I hereby authorize the above amounts to be deducted from my pay.

By signing this form, I declare that I have read and understood these terms.

Signature:_____ Date:_____