

**2026 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**

<u>Plan B</u> <b>BROAD</b>	<u>Monthly</u>	<u>Pre-tax</u>	<u>Plan B</u> <b>MEMORIAL</b>	<u>Monthly</u>	<u>Pre-tax</u>	<u>Plan B</u> <b>KELSEY</b>	<u>Monthly</u>	<u>Pre-tax</u>
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)

<u>Plan C</u> <b>BROAD</b>	<u>Monthly</u>	<u>Pre-tax</u>	<u>Plan C</u> <b>MEMORIAL</b>	<u>Monthly</u>	<u>Pre-tax</u>	<u>Plan C</u> <b>KELSEY</b>	<u>Monthly</u>	<u>Pre-tax</u>
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: HUMANA** (Please type X next to only one dental and vision option or decline coverage)

<u>DHMO</u>	<u>Monthly</u>	<u>Pre-tax</u>	<u>DPPO</u>	<u>Monthly</u>	<u>Pre-tax</u>
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 coverage: \_\_\_\_\_

**Vision Insurance: CEC (COMMUNITY EYE CARE)**

<u>PPO Vision</u>		
Employee Only	\$7.06	_____ (2435)
Employee+Spouse	\$14.11	_____ (2436)
Employee+Child(ren)	\$14.54	_____ (2437)
Employee+Family	\$20.12	_____ (2438)

Decline vision coverage: \_\_\_\_\_

**I hereby authorize the above amounts to be deducted from my pay. A Bio-Metric Screening must be completed to pay the premiums shown on this form.**

**Failure to complete a Bio-Metric Screening before the deadline 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: \_\_\_\_\_

## 2026 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 = \$3,400 / yearly)      (Max dependent Care = \$5,000 / 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 01/01/2026:** \_\_\_\_\_

Decline _____	Coverage	Rate	B/W Ded Amount	<b>Life Insurance Rates (24x)</b>	
				Age	Rate
(2667) Employee Additional Life Insurance	X	_____	\$ _____	<b>&lt;24</b>	<b>0.0250</b>
				<b>25-29</b>	<b>0.0350</b>
(2668) Employee (AD&D)	X	0.0100	\$ _____	<b>30-34</b>	<b>0.0350</b>
				<b>35-39</b>	<b>0.0525</b>
(2669) Spouse Life Insurance	X	_____	\$ _____	<b>40-44</b>	<b>0.0725</b>
				<b>45-49</b>	<b>0.0975</b>
(2670) Spouse (AD&D)	X	0.0175	\$ _____	<b>50-54</b>	<b>0.1780</b>
				<b>55-59</b>	<b>0.2990</b>
(2671) Child/Children Life Insurance	X	0.1255	\$ _____	<b>60-64</b>	<b>0.4450</b>
				<b>65-69</b>	<b>65% 0.7600</b>
(2672) Child/Children (AD&D)	X	0.0175	\$ _____	<b>70-74</b>	<b>50% 1.4750</b>
				<b>75+</b>	<b>50% 2.9800</b>

**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: \_\_\_\_\_