

Benefit Enrollment Worksheet for the Period of 1/1/2019 through 12/31/2019

Dollars paid by  
Employer  
per paycheck  
\$77.00  
\$120.00  
\$119.00  
\$170.00

- Option A:** For Employees who elect a Medical Plan with **Employee Only** coverage
- Option B:** For Employees who elect a Medical Plan with **Employee & Spouse** coverage
- Option C:** For Employees who elect a Medical Plan with **Employee & Child(ren)** coverage
- Option D:** For Employees who elect a Medical Plan with **Family** coverage

Medical Plans

**Total Cost per Paycheck**

Plan Choices	Waiver	A	B	C	D
Plan 1 \$1000 Deductible		\$156.08	\$312.16	\$280.94	\$468.23
Plan 2 \$2000 Deductible		\$138.12	\$276.23	\$248.61	\$414.35
Plan 3 \$5000 Deductible		\$133.68	\$267.35	\$240.62	\$401.03
Plan 4 \$3500 HSA		\$96.39	\$192.78	\$173.50	\$289.17

Dental Plan

Delta Dental

Waiver	A	B	C	D
	7.68	15.12	15.66	27.09

Vision Plan

VIPA

Waiver	A	B	C	D
	1.78	3.56	3.56	4.71

Accidental Death & Dismemberment

Life Insurance Policy 1 times Salary

<b>No Cost</b>
<b>No Cost</b>

Line A: Add all Premiums above: \_\_\_\_\_

Line B: List Employer Contribution: \_\_\_\_\_

Line C: Subtract Line B from Line A  
Employee Total Cost Per Paycheck \_\_\_\_\_

Employee Name (Print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I understand that the choices I have indicated on the worksheet must remain in effect for the entire plan year unless I have a change in family status.

A change in family status includes the birth of adoption of a child, marriage, divorce, death, spouse losing/gaining a job or employment status from part-time to full-time or full-time to part-time.

I hereby give my employer permission to reduce my salary by the above-elected amounts.  
I understand that premiums I am obligated to pay for will be deducted from my pay on a before-tax basis.