BENEFIT ELECTION
FY2020-21

Effective Date: _____

EMPLOYEE INFORMATION

Employee Name

Last	First	Middle Initial	SSN

Address

Address	City	State	ZIP

Emergency Contact

Name	Relation	Emerg Phone

Dependent premium deductions are based on 24 payments per year. No deductions taken when there is a 3rd PAYDAY in the month.

INSURANCE SELECTION

HEALTH INSURANCE

☐ **Employee** *$ -covered-*	☐ **Employee +Spouse** *$813.00 /mo* *$406.50 /ppd*	☐ **Employee +Children** *$482.00 /mo* *$241.00 /ppd* ☐ **Employee +Child** *$301.00 /mo* *$150.50 /ppd*	☐ **Family** *$1202.00 /mo* *$601.00 /ppd*	☐ **Decline**

VISION INSURANCE

☐ **Employee** *$ -covered-*	☐ **Employee +Spouse** *$6.00 /mo* *$3.00 /ppd*	☐ **Employee +Children** *$6.00 /mo* *$3.00 /ppd*	☐ **Family** *$13.00 /mo* *$6.50 /ppd*	☐ **Decline**

DENTAL INSURANCE

☐ **Employee** *$ -covered-*	☐ **Employee +Spouse** *$31.00 /mo* *$15.50 /ppd*	☐ **Employee +Children** *$56.00 /mo* *$28.00 /ppd*	☐ **Family** *$68.00 /mo* *$34.00 /ppd*	☐ **Decline**

FLEXIBLE SPENDING ACCOUNT

☐ **Medical** (max $2,750/yr)	*$_____ per year*
☐ **Dependent Care** (max $5,000/yr)	*$_____ per year*

DEPENDENT INFORMATION (if coverage is chosen above)

First and Last Name	Relation to Insured	DOB	SSN

_____ _____

Employee Signature **Date**

REV May 2020