Rochester Community Schools – Secretaries

2024 Election Form - Plan Year: January 1, 2024 - December 31, 2024

Complete only if you are making changes, newly enrolling, opting-out of medical or contributing to a Flexible Spending Account You must complete all sections of this form, regardless if you are already covered under the plan

Middle Initial

DEN# _____

Date of Hire

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Name

Address_

DEPENDENT INFORMATION - List those individuals to be covered under the Medical, Dental and/or Vision Plans LAST NAME FIRST GENDER BIRTHOATE MEDICAL DENTAL VISION Spouse Add	Date of Rirth	[☐ Male ☐ Female	, ,	Work Location		# Pays (26 o	r 21)
Care								•
Spouse	DEPENDENT IN	IFORMATION - List th	ose individuals to	be cover	ed under the M	ledical, Den	tal and/or Vis	sion Plans
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BENEFIT SELECTIONS Medical Plan - Blue Cross Blue Shield of Michigan Choose one of the following options BCBSM PPO Medical Plan Single \$65.21 \$80.73 \$193.76 Family \$155.50 \$193.76 Family \$155.63 \$242.20 BCBSM HSA Medical Plan Per Pay - 26 Pay Cycle Per Pay - 21 Pay Cy	Child					☐ Add	☐ Add	☐ Add
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Optional Life/AD&D Table

Monthly cost per \$1,000

Employee

\$0.055

\$0.055

\$0.065

\$0.085

\$0.105

\$0.155

\$0.245

\$0.405

\$0.565

\$1.005

\$1.625

<u>Spouse</u>

\$ 0.065

\$ 0.075

\$ 0.095

\$ 0.105

\$ 0.125

\$ 0.185

\$ 0.325

\$ 0.525

\$ 0.945

\$ 1.605

N/A

<u>Age</u>

25 - 29

30 - 34

35 - 39

40 - 44

45 - 49

50 - 54

55 - 59

60 - 64

65 - 69

70+

Under 25

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Dental and Vision Plans - Blue Cross Blue Shield of Michigan

If you enroll in medical coverage, you will automatically be enrolled in the same dental and vision coverage tier as your medical election.

r you opt-out of medical coverage, choose one of the following options	
BCBSM Dental and Vision Plans	Per Pay – 26/21 Pay Cycle
☐ Single	\$0.00
☐ Single + 1	\$0.00
☐ Family	\$0.00
<u> </u>	

5

Flexible Spending Accounts - Basic and Health Savings Account (HSA):

	Maximum Annual Elections	Annual Election	Pay Period Frequency	Per Pay Amount
Health Care FSA -Limited FSA if enrolling in the HDHP	\$3,200	\$	26 or 21	\$
Dependent Care FSA	\$5,000	\$	26 or 21	\$
Health Savings Account	\$4,150 for single \$8,300 for family	\$	26 or 21	\$
-Only available with HSA Medical Plan (minus any money contributed by Rochester Schools) Rochester Schools will contribute \$800 for single coverage or \$1,600 coverage if you enroll yourself and your dependent(s) in the HSA medical Plan				

6

Life and Accidental Death and Dismemberment – The Standard

You must complete a Statement of Health, found on the Rochester Community Schools website, if your Optional Life/AD&D election is subject to evidence of insurability as detailed in the Benefit Guide

Basic Life and AD&D Plan - Rochester Schools provides Life and AD&D insurance of \$45,000 if you enroll in medical; or, \$95,000 if you opt-out of medical

Optional Life and AD&D Plan: You must elect for employee before spouse coverage can be elected

Employee -	- may purchase Optional Life and AD&D insurance ir	n increments of \$10,000 up to
	\$500,000, enter your election in the table below & c	alculate your cost
\$	/\$1,000 X \$	=

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Spouse - may purchase Optional Life a	and AD&D insurance in incremen	nts of \$10,000 up to
Φ4ΕΟ ΟΟΟt		

\$150,000, enter your election in the table below & calculate your cost				
\$	/ \$1,000 X \$		=	
Must evenly divide \$10,000	-	Rate (Table)		Cost per month

Rate (Table)

Children – may purchase Optional Life and AD&	insurance in increments of \$2,500 to	up to \$10,000, circle your election & cost below

\$2,500 \$ 0.54 \$7,500 \$ 1.61 \$5,000 \$ 1.08 \$10,000 \$ 2.15

BENEFICIARY INFORMATION - If you want to change or update your beneficiary, please complete a The Standard Beneficiary form found on the Rochester Community Schools website

Cost per month

7

SIGNATURE - Please read and sign below

Must evenly divide \$10 000

I wish to make the choices indicated on this form and authorize Rochester Community Schools to make any necessary pre-tax or after-tax payroll adjustments. I understand that these elections are effective January 1, 2024 through December 31, 2024. I understand that I am required to reimburse Rochester Community Schools for all elected benefits either during or after any authorized leave. I understand that Rochester Community Schools retains the right to amend, modify, or terminate this Plan at any time.

I understand that pre-tax contributions will slightly impact my social security contributions. I understand that I need to use any dollars I've deposited in the Health Care and Dependent Care Reimbursement Accounts by year-end or they will be forfeited. Adjustments may be necessary to comply with IRS discrimination tests. I am aware that the plan maximum may be reduced to maintain compliance with IRS regulations.

I understand that this election is irrevocable until next plan year unless there is an allowable change in family status that occurs and I notify Department of Human Resources within 30 days of the allowable change. I certify the information on this form is complete and accurate. Any person who, with intent to defraud or knowing that they are facilitating a fraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I understand there shall be no duplication of hospitalization benefit. I must notify the Department of Human Resources of any personal, duplicated benefit coverage – either through personal coverage or coverage from spouse's or family's benefit plan. If I am covered by any other duplicated hospitalization benefit, the Employer's obligations under this benefit shall be waived.

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\Rightarrow	Signature	Date