



# EMPLOYEE BENEFIT ELECTION FORM - OCT 2011 to SEPT 2012

<input type="checkbox"/> Open Enrollment	<b>EFFECTIVE DATE:</b>	
<input type="checkbox"/> Status Change or Approved Deduction Change		<input type="checkbox"/> EXEMPT
<input type="checkbox"/> New Hire		<input type="checkbox"/> Non-Exempt

EMPLOYEE NAME (Please Print)

**New Employees are eligible on the 1st day of the month, following 30 (EX) or 90 (NE) days of FT equivalent employment.**

## A. \$10,000 in BASIC LIFE, \$10,000 ACCIDENTAL DEATH, & EAP (Employee Assistance Program) - PAID BY NH

Primary Beneficiary:	Relation/Percentage:
Secondary Beneficiary:	Relation/Percentage:

**Instructions: Electing?** Enter your contribution for each benefit in the Monthly cost column (non-colored cells only). **Same coverage?** If you are not making any change, click the "same" box. **Declining?** If you are declining covering for this period, click the "decline box".

## HEALTHCARE OPTIONS

### B. MEDICAL INSURANCE Plans (PreTax) Network providers listed at www.uhwest.com or www.kp.com

U = United Hlth Care or K = Kaiser	<input type="checkbox"/> U LOW Low-524924	<input type="checkbox"/> U HIGH High-524922	<input type="checkbox"/> K LOW Low-131397-000	<input type="checkbox"/> K HIGH High-131397-001	<b>Medical (B)</b>	
Office Copay - note, w chiro & acupuncture Indiv. Hospital Copay (year max) Prescrip Drugs - gen/brand/non	HMO \$20 30% (\$3K) \$15/\$35/\$50	HMO \$20 -wC&A \$250 (\$1.5K) \$15/\$35/\$50	HMO \$30 \$500/day (\$3K) \$15/\$30/\$-	HMO \$15 - wC \$250 (\$1.5K) \$15/\$30/\$-	<input type="checkbox"/> Same	<input type="checkbox"/> Decline, initial:

### NH contribution (averaging \$320/month) reflected in cost of all premiums.

	\$105.34	\$147.53	\$86.90	\$124.48	Input B \$	Per Pay Cost
<input type="checkbox"/> EMPLOYEE Only						
<input type="checkbox"/> EMPLOYEE + Spouse/Ptnr	\$654.84	\$737.60	\$540.29	\$623.39		
<input type="checkbox"/> EMPLOYEE + Child(ren)	\$563.22	\$639.19	\$464.72	\$539.40		
<input type="checkbox"/> FAMILY	\$943.33	\$1,047.38	\$778.31	\$883.79		

### C. DENTAL INSURANCE - Principal (PreTax) - Check for In-Network Providers at www.principal.com (HMO plan through www.caldental.net)

<b>NH pays 50% of EE Costs</b> (100% if medical not elected, input 0)	<input type="checkbox"/> HMO Advantage 75	<input type="checkbox"/> POS-Low Principal	<input type="checkbox"/> POS-High Principal	<b>*HMO</b> *Flat fee w specific dentists.	<input type="checkbox"/> Declining	<b>Initial:</b>
<input type="checkbox"/> EMPLOYEE Only	\$6.85	\$13.02	\$17.64			
<input type="checkbox"/> EMPLOYEE + Spouse/Ptnr	\$17.59	\$38.62	\$52.21	<b>PPO-Low or HI</b>	<b>Input C \$</b>	<b>Per Pay Cost</b>
<input type="checkbox"/> EMPLOYEE + Child(ren)	\$19.82	\$38.13	\$52.53	% of cost covered		
<input type="checkbox"/> FAMILY	\$30.93	\$66.21	\$90.56	\$1.5K max/\$50 ded.		

### D. VISION INSURANCE - United Health (PreTax) Plan V0022 www.myuhcspecialtybenefits.com (vision)

Group 09H2900	<input type="checkbox"/> Declining	<input type="checkbox"/> EE Only	<input type="checkbox"/> EE+ 1	<input type="checkbox"/> EE +2 +	<b>Input D \$</b>	<b>Per Pay Cost</b>
No NH Contribution (unless 0 med)	\$0.00	\$7.08	\$14.12	\$19.80		

## TOTAL HEALTHCARE PREMIUMS (Pretax unless noted below)

## VOLUNTARY OPTIONS (Pre and After Tax)

### E. PRE-TAX REIMBURSEMENT PLANS Pay eligible expenses in favorable pretax dollars - MAX \$3,000/yr. Initial:

Premium Only (Yes, unless No selected here)	<input type="checkbox"/> No	Annual Election	Mo. Deductions	<b>Monthly</b>	<b>Per Pay</b>
Dependent Day Care (Child/Elder)	<input type="checkbox"/> Yes <input type="checkbox"/> No		12		
Medical Reimbursement (URM)	<input type="checkbox"/> Yes <input type="checkbox"/> No				

### F. 403B RETIREMENT ACCOUNT (PreTax) No Yes - appt. req. \_ Monthly Per Pay

**\$16.5K Annual Max+ may be eligible for \$5.5K in catch up contributions, if eligible (over age 50)**  
Hardship withdrawals subject to penalties & 6 reinvestment month wait Anticipate debit to begin: \_\_\_\_\_

### G. VOLUNTARY LIFE INSURANCE AND AD&D through UNUM (After tax benefit) (See tables for rates)

(EE up to \$500k, guarantee issue - \$100K, AD&D to \$300K (max 5 times annual salary, spouse and children amounts less))

Input factor from insurance table under F	F	Term Life	Vol Life Premium	AD&D Amount	AD&D Premium	<b>Monthly</b>	<b>Per Pay Cost</b>
<input type="checkbox"/> EMPLOYEE Only							
<input type="checkbox"/> Employee's Spouse/Partner							
<input type="checkbox"/> Employee's Child/Children							
<b>Total Cost</b>							

### H. UNITED WAY (Voluntary per pay contribution) Input H \$

### I. SHORT TERM DISABILITY / ACCIDENT DISABILITY (AFLAC) FT EES only - (After tax benefit) Monthly Per Pay

Monthly Benefit Requested:	Waiting Period:	Approved date:
Benefit Mos. <input type="checkbox"/> 6 Month <input type="checkbox"/> 12 Month <input type="checkbox"/> 24 Month		

Each paycheck will be reduced by the amount in the Semi-Monthly column to cover the cost of the benefits you have elected.

## TOTAL OF ALL PREMIUMS

I authorize New Haven Youth and Family Services Inc to make **deductions from my earnings** for the cost of participation in the plan **benefits elected above**. I understand that by declining coverage in insurance plans and/or Flex Plan Accounts for my dependents or myself at this time, I may not be eligible to enroll in these insurance plans until the next open enrollment period unless there is a qualifying event. I understand my coverage/benefits may be affected by failure to provide complete/accurate information. I certify that features & benefits of the Flexible Benefits Plan have been explained to me including the knowledge that Pre-tax contributions reduce my compensation for Social Security tax purposes and therefore could decrease those benefits. I elect to receive elected coverages as pre-tax unless this agreement is amended or terminated, these deductions are continuous and in an equal amount to the insurance deducted from my salary without signing a new Salary Redirection Agreement.

If the rate change is brought on by the third-party carrier (insurance company), the premium increase or decrease can be deducted pre-tax. Any previous elections are revoked as of this new benefit period & my employer's deduction shall evidence acceptance of this Agreement. **AUTHORIZATION TO OBTAIN RELEASE OF MEDICAL INFORMATION:** I authorize my physician, hospital, or any other designated medical facility to furnish an agent, designee, or representative of the Health Plan with any/all records pertaining to medical history, including any Mental Health, Psychiatric records, Substance Abuse and any records pertaining to Acquired Immune Deficiency Syndrome(AIDS), at any time while I am a member, including services rendered, or treatment given to anyone enrolled hereunder or added hereafter for the purposes of utilization review, quality assurance, surveys, processing of claims, financial, or to perform internal administrative functions.

EMPLOYEE SIGNATURE:

DATE: