EMPLOYEE BENEFIT ELECTION FORM - October 2009-September 2010

EMPLOYEE NAME (Please Print)

☐ New Hire
☐ Open Enrollment
☐ Status Change or Approved Deduction Change

EFFECTIVE DATE: ________

☐ Non-Exempt
☐ EXEMPT

PLEASE SELECT DESIRED COVERAGES BELOW — Conditions and/or eligibility requirements may apply for enrollments

A. HEALTH INSURANCE Plans *(PreTax)*

Network providers listed at www.pacificare.com or www.kp.com

NEW HAVEN PAYS 80% of EE Costs in Low Plan / 75% or EE Costs in HI Plans - either Network

Premiums adjustments already reflected in contributions

P = Pacificare or K = Kaiser	☐ P LOW Low-524924	☐ P HIGH High-524922	☐ K LOW Low-131397-000	☐ K HIGH High-131397-001	☐ Waiving Healthcare *Initial:*	
Office Copay Hospital Copay (plan indiv max cost) Prescrip Drugs - generic/brand/non-form	HMO $25 30% ($2K) $15/$30/$45	HMO $20 - wC $250 ($2K) $15/$30/$45	HMO $30 $500/day ($3K) $10/$30/ -	HMO $15 - wC $250 ($1.5K) $15/$30/$ -	**A = MEDICAL** **wC means with Chiropractic Benefit**	
☐ EMPLOYEE Only	**$72.00**	**$94.77**	**$60.57**	**$83.05**	**Monthly**	**Semi-Monthly**
☐ EMPLOYEE + Spouse/Ptnr	**$503.96**	**$549.63**	**$424.01**	**$481.67**		
☐ EMPLOYEE + Child(ren)	**$431.95**	**$473.80**	**$363.43**	**$415.23**		
☐ FAMILY	**$730.74**	**$788.44**	**$614.81**	**$690.94**		

B. DENTAL INSURANCE - Golden West Dental *(PreTax)*

Check for In-Network Providers at www.goldenwestdental.com

NEW HAVEN PAYS $7.08 towards EE Costs in PrePaid Plan /$11.59 of EE costs in PPO-Low or $12.74 in PPO-H

New Haven Group #NP9164	☐ PrePaid 89L 1301	☐ PPO-Low CLMS0201	☐ PPO-High CLMS0501	***PrePaid** Flat fee w specific dentists. No Max.	☐ Waiving	*Initial:*
					B = Dental Cost	
☐ EMPLOYEE Only	**$7.08**	**$17.38**	**$38.21**			
☐ EMPLOYEE + Spouse/Ptnr	**$18.75**	**$46.93**	**$90.08**	**PPO-Low or HI**	**Monthly**	**Semi-Monthly**
☐ EMPLOYEE + Child(ren)	**$17.45**	**$45.40**	**$87.37**	% of cost covered		
☐ FAMILY	**$25.84**	**$74.97**	**$139.24**	$1K max/$50 ded.		

C. VISION INSURANCE - PACIFICARE *(PreTax)* *www.pacificare.com*

New Haven Group #88	☐ Plan 49OFS		☐ Waiving	*Initial:*
☐ EMPLOYEE Only	**$7.08**	**Vision Ins Cost**	**C = Vision Cost**	
☐ EMPLOYEE + Spouse/Ptnr	**$14.12**	**No NH**	**Monthly**	**Semi-Monthly**
☐ EMPLOYEE + Child(ren)	**$14.12**	Contribution		
☐ FAMILY	**$19.80**	to Vision		

YOUR MONTHLY and SEMI-MONTHLY HEALTHCARE **DEDUCTION (Cost)** :

ADDITIONAL OPTIONS *(Pre and After Tax)* — **No NH Contribution but still affordable options**

D. PRE-TAX Reimbursement Plans

Pay eligible expenses in favorable pretax dollars — ☐ Waiving *Initial:*

	Annual Election	Mo. Deductions	**Monthly**	**Semi-Monthly**
Dependent Day Care (Child/Elder)				
Medical Reimbursement (URM)		12		

E. 403B RETIREMENT ACCOUNT *(PreTax)*

Save for the future! ☐ Appointment — **Monthly** | **Semi-Monthly**

$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:___________

F. LIFE INSURANCE through UNUM with AD&D - *AFTER TAX*

Rates for term based on actual tables related to age & smoker/nonsmoker — ☐ Waiving Life Insur — *Initial:*

New Haven Group #00201619	Insurance Amt	Ins Premium	AD&D Amount	AD&D Premium	**Monthly**	**Semi-Monthly**
☐ EMPLOYEE Only						
☐ Employee's Spouse/Partner						
☐ Employee's Child/Children						
Total Cost						

G. SHORT TERM DISABILITY / ACCIDENT DISABILITY through AFLAC (Full Time Employees only) - *AFTER TAX*

☐ Waiving

Benefit Requested:		Elim Pd:	Month Income Insured:	**Monthly**	**Semi-Monthly**
☐ 6 Month	___Given App	___App Rec'd	___Submitted		**$0.00**
☐ 12 Month ☐ 24 Month				**Monthly**	**Semi-Monthly**
		TOTAL OF ALL DEDUCTIONS			

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

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. 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 mycompensation*** *for Social Security tax purposes and therefore could decrease those benefits. I* ***elect to receive elected coverages as pre-tax as indicated above.*** *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:**