Garden City Public Schools Election/Change of Status Form

Section 1 – Employee Information *Please print information about yourself.* Union/Employee Group:_____

Employee Name (Last, First, M.I.)	Date of Birth	Social Security #	M/F	Address, City, State & Zip

Please check the appropriate box: NEW HIRE ☐ OPEN ENROLLMENT/CHANGE IN STATUS ☐

Section 2 — Benefits Selection *Please make your benefit selection in the following chart.*

Benefit	Selections
A. Medical Plan (monthly deductions listed below): ☐ Community Blue 3 (Single: $364.27, 2Person: $1,043.00, Family: $1,241.89) ☐ Community Blue 4 (Single: $298.94, 2Person: $886.21 , Family: $1,045.90) ☐ Community Blue 5 (Single: $119.11, 2Person: $454.63, Family: $506.43) ☐ BCN HDHP HSA 1 (Single: $0.00, 2Person: $0.00, Family: $0.00) ☐ BCN HDHP HSA 2 (Single: $0.00, 2Person: $0.00, Family: $0.00) *-PLEASE SIGN **SECTION 4** IF ENROLLING IN A MEDICAL PLAN* ☐ Decline Medical (Waive) – Proof of Other Coverage Required-***Must sign Medical Waiver*** Do you have medical coverage through another source? ☐ Yes ☐ No (If yes, you must provide a copy of the insurance card.)	*Check your status below:* ☐ Single ☐ Two Person ☐ Family
B. *Health Savings Account (HSA) - Employee Funding for BCN HDHP HAS 1 or 2 Plans Only. Complete this section if you are funding your HSA ☐ Employee HSA Deduction ☐ No Employee HSA Deduction *You Must Also Complete **Section 5***	$_____ One Time Lump Sum $_____ Per Pay
C. Flexible Spending Account (FSA): ☐ Health Care Account (only available those enrolling in the Community Blue PPO plans, those Opting Out of Medical Coverage, or those enrolled in a HDHP but not eligible to contribute) ☐ Dependent Care Account (available to all benefit eligible employees) ☐ Not Participating or Enrolling	Please Complete the PlanSource Enrollment Form **This will be sent out in a separate email.**
D. Dental Plan: ☐ Dental Enrollment ☐ Decline Dental Do you have coverage through another source? ☐ Yes ☐ No (This information is need to ensure the 2 plans will coordinate coverage.)	*Check your status below:* ☐ Single ☐ Two Person ☐ Family
E. Vision Plan: ☐ Vision Enrollment ☐ Decline Vision	*Check your status below:* ☐ Single ☐ Two Person ☐ Family

Section 3 —Spouse/ Dependent Information

Please print information about your spouse/dependents in the following chart.

***** Complete Below Only If You Are Electing to Cover or Remove Coverage from Any Dependents*****

Full Name	SSN	Gender	Birthdate	Relationship	Medical	Dental	Vision
Spouse					☐ Enroll ☐ Decline	☐ Enroll ☐ Decline	☐ Enroll ☐ Decline
Dep					☐ Enroll ☐ Decline	☐ Enroll ☐ Decline	☐ Enroll ☐ Decline
Dep					☐ Enroll ☐ Decline	☐ Enroll ☐ Decline	☐ Enroll ☐ Decline
Dep					☐ Enroll ☐ Decline	☐ Enroll ☐ Decline	☐ Enroll ☐ Decline
Dep					☐ Enroll ☐ Decline	☐ Enroll ☐ Decline	☐ Enroll ☐ Decline

Section 4 — Pre-Tax Authorization for Payroll Deductions

I understand that:

-- I agree and consent to a reduction in my pre-tax compensation equal to the amount of the employee contribution premium costs for benefit coverages in accordance with my elections. The employee contribution portion is an amount determined under the collective bargaining agreement, administrator contract or individual manager/supervisor contract applicable to me or by law.

-- I cannot change or revoke this benefit election agreement as of any date prior to the next January 1st unless I have a change in family status (e.g., a change in legal marital status, a change in the number of dependents, etc.). In addition, I understand that the Plan Administrator may change my election with respect to medical care coverage to the extent that a judgment, decree, or order requires coverage under a group health plan in which I am enrolled through the District and may permit me to change or cancel medical care coverage for a dependent if the order requires my former spouse to provide coverage. Further, the Plan Administrator may permit me to make an election change relating to the medical care coverage to the extent that I, my spouse, or dependent becomes entitled to coverage under Medicare. Any change in the benefit election agreement must be made within 30 days of the qualifying event and be permitted by the applicable insurance compan(ies).

-- If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pre-tax pay reduction will automatically be adjusted to reflect that increase or decrease.

-- Prior to January 1st of the next Plan Year, I will be offered the opportunity to change my benefit election(s) for the Plan Year starting January 1st and ending on December 31st. If I do not complete and return a new election form, I will be treated as having elected to continue any benefit coverage then in effect for the new Plan Year. In addition, any compensation reduction agreement will continue by its terms in the amount of the required contribution for the Plan Year. This does not apply to FSA elections.

-- The District may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the Plan if believed advisable in order to satisfy certain provisions of the Internal Revenue Code.

Employee Signature:_____ Date:_____

Section 5 – Certification of HSA Eligibility (Only Applies if electing one of the BCN HDHP HSA Plans)

Only individuals who meet certain requirements are eligible to make contributions to a health savings account (HSA). The purpose of this section is to confirm that you meet those requirements and are eligible to make and receive contributions to an HSA.

Please note: Complete this section carefully. If you have any general questions regarding the form, please contact Corri Siwik in the Benefit's Department. For specific questions regarding your personal situation, please consult your tax advisor. You must be able to satisfy each element to be eligible for contributions. Please retain a copy of this form with your important tax records.

Please read and initial each of the following items:

1. **High deductible major medical coverage**.
   I have ☐ self-only OR ☐ family coverage under the BCN – High Deductible Health Plan which I understand qualifies as a high deductible health plan under Code § 223. *For more information, see paragraph A.* *Initial* _____

2. I cannot be claimed as a dependent on another person's federal tax return. *Initial* _____

3. I am not enrolled in Medicare. *Initial* _____

4. I am not covered under any of the following "other" types of health coverage:
   - Comprehensive coverage (other than HDHP described in 1. above), including through my spouse's employer (i.e., double covered). *For more information, see paragraph C on the attached page.* *Initial* _____
   - Medical reimbursement account under my employer's cafeteria plan. *Initial* _____
   - Medical reimbursement account under the cafeteria plan of my spouse's employer. *For more information, see paragraph C on the attached page.* *Initial* _____
   - Health reimbursement arrangement ("HRA") sponsored by my employer. *Initial* _____
   - Health reimbursement arrangement ("HRA") sponsored by a prior employer. *Initial* _____
   - Health reimbursement arrangement ("HRA") sponsored by the employer or former employer of my spouse. *For more information, see paragraph C on the attached page.* *Initial* _____
   - Covered under any other coverages other than "permitted" coverages. *Initial* _____

   "Permitted" coverages include coverages for liability, accidents, disability, specific diseases, fixed indemnity, dental care, vision care, and long-term care. *For more information, see paragraph B*

By signing this form and returning it to my employer, I certify that all of the statements above are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the above HSA eligibility conditions and I agree that if I cease to meet any of these conditions, I will notify my employer immediately in writing at 1333 Radcliff, Garden City MI 48135. My HSA contributions (if any) are subject to certain aggregate limits under federal tax law.

A. HDHP coverage is health coverage that meets the following requirements:

- Self-Only Coverage: Self-only coverage is coverage of one individual. To qualify as HDHP coverage, it must have a deductible of at least $1,350 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care). In addition, the sum of the deductible and other annual out-of-pocket expenses that the insured is required to pay (such as co-pays and co-insurance, but not premiums) cannot exceed $6,650 (as indexed for inflation).

- Family Coverage: Family coverage is any coverage other than self-only coverage. Family HDHP must have a deductible of at least $2,700 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care). No amounts can be paid (other than for preventive care) until the minimum required family deductible has been satisfied (i.e., there cannot be an individual deductible within the family deductible that is less than the required minimum of $2,700, as indexed for inflation). In addition, the sum of the deductible and other annual out-of-pocket expenses that the insured is required to pay (such as co-payments and co-insurance, but not premiums) cannot exceed $13,300 (as indexed for inflation).

B. Permitted non-HDHP insurance or coverage is:

a. insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., home-owner or auto insurance), or similar liabilities as specified by the IRS;

b. insurance for a specified disease or illness (e.g., cancer insurance);

c. insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance); or

d. coverage for accidents, disability, dental care, vision care, or long-term care, including some medical reimbursement accounts and health reimbursement arrangements (HRAs) (e.g., limited purpose medical reimbursement accounts and HRAs, suspended HRAs, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs) and some wellness programs and employee assistance programs (e.g., those that do not provide significant benefits in the nature of non-preventive medical care or treatment).

C. Special Rule for Married Individuals:

a. If your spouse has family coverage under another plan and you are covered by it, that coverage must qualify as HDHP coverage in order for you to be eligible for HSA contributions. For example, if your spouse has family coverage under an HMO or a low-deductible medical plan, then you would be ineligible for HSA contributions. You would also be ineligible for HSA contributions if your spouse participates in a medical reimbursement plan or health reimbursement arrangement that reimburses expenses incurred by a participant's spouse. In addition, the amount of your HSA contributions may be limited if your spouse has HDHP family coverage.

HSA Authorization

_____ _____

Employee Signature Date

_____ _____

Employee Social Security Number Please Print Employee Name and Daytime Telephone Number

Section 6 – Acknowledgement

I have received and read the printed material explaining the 2018 GCPS group benefit program and my choices under the program. I understand that by signing and submitting this enrollment form, I am making binding coverage elections or waiving coverage for the plan year, and that the only time changes can be made is if I experience a qualified family status change.

Each year during open enrollment I can change my election. If I do not complete and return a form at that time, this election will continue unchanged at the new deduction amount until I make a new election under the terms of the plan.

Employee Signature_____ Date _____

Medical Waiver

(ONLY TO BE COMPLETED IF YOU ARE DECLINING MEDICAL COVERAGE)

ACKNOWLEDGMENT OF **DECLINED** OFFER OF GROUP HEALTH COVERAGE

I acknowledge that I have been given the opportunity to enroll in group health coverage offered by the GCPS and decline the opportunity to enroll in this coverage. I understand that I will not have another opportunity to enroll in group health coverage offered by the District until the next open enrollment period or the date of a qualifying event (if any) permitting earlier enrollment, assuming that I am otherwise eligible to enroll in coverage at that time. I understand that, unless I have health coverage that satisfies my individual responsibility under the Affordable Care Act, I may be assessed a tax penalty for my failure to obtain coverage. I further understand that, even if I satisfy applicable household income requirements, I may not be eligible for a tax credit or subsidy for health coverage that I purchase on a health care exchange (Health Insurance Marketplace) for any month in which I was given the opportunity to participate in the District's group health coverage.

I understand that I must provide proof of other coverage by attaching a copy of my insurance card to this form in order to be eligible for any applicable contractual cash in lieu.

Employee Signature:_____ Date:_____

Life Insurance Beneficiary Form (Designation of Beneficiary)

Policy Holder: Garden City Public Schools	Policy Number(s): GL 675105
Insured Name	Social Security Number

I hereby designate the following as my beneficiary(ies) under the above policy number(s):

Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (must total 100%)	Date of Birth	Relationship	Social Security Number

*If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (must total 100%)	Date of Birth	Relationship	Social Security Number

*If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- This beneficiary designation revokes all revocable prior beneficiary designations.
- Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rated among the surviving beneficiaries of the same class (primary or contingent).
- If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured