2015 ADMINISTRATORS BENEFITS ENROLLMENT & CHANGE FORM

Employee Information

Employee Last Name ________ First Name ________ M.I. ____ Date of Birth ________ Social Security Number ________

Street Address ________ City ________ State ____ Zip ____ County ________ Phone Number ________

Marital Status:

☐ Married ☐ Single

Gender:

☐ Male ☐ Female

Employee Elections

MEDICAL (Monthly Deduction Listed Below)

☐ **BCBSM Community Blue 1**
Single: $179.98 Two Person: $584.55
Family: $679.94

☐ **BCBSM Community Blue 3**
Single: $54.07 Two Person: $282.38
Family: $302.24

☐ **BCBSM Simply Blue HDHP/HSA**
Single: $0.00 Two Person: $0.00
Family: $0.00

☐ **Waiver Medical Coverage:** Complete Waiver of Coverage on reverse side if waiving medical. *Please see reverse side if you maintain other health or dental insurance.*

DENTAL BCBSM

☐ **Elect** ☐ **Waive**

VISION NVA

☐ **Elect** ☐ **Waive**

Dependent Information

Full Name	Social Security Number	Gender	Birthdate	Medical	Dental	Vision
Spouse				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term
Dep				☐Enroll ☐Term	☐Enroll ☐Term	☐Enroll ☐Term

I understand that the benefit elections I make now will remain in effect for the entire plan year and that I may not terminate or change them during the plan year unless I have a Change in Status Event and am eligible for a Special Enrollment Period. I understand that I am responsible for giving written notice to the Benefits Department within 30 days of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or deaths of anyone covered under my policy.

By signing this enrollment form, I acknowledge I have received a copy of the Summary of Benefits and Coverage (SBC) for the medical plan(s) effective for the benefit plan year outlined above. Each year during the annual Open Enrollment period, I will have an opportunity to change my election. If I do not complete and return a new form at that time, this election will continue unchanged until I make a new election under the terms of the plan.

I understand that I need to contribute to the cost of these benefits and I authorize my employer to deduct the required Benefit Contributions, including any increases or decreases the Plan may require from those listed in the Benefit Guide, on a pre-tax basis from my earnings. I hereby certify that the statements herein are complete and accurate to the best of my knowledge. I understand benefits could be affected if I knowingly provide false, incomplete, or misleading information on this form.

EMPLOYEE SIGNATURE: ________________________ **DATE SIGNED:** ____________

Supplemental Life

If interested in purchasing additional Life insurance please contact Anne Waldron.

Flexible Spending Account (FSA)

In order to participate in the Health Care FSA and/or Dependent Care FSA, you must complete a NGE Election Form. Please contact Anne Waldron for FSA packet.

Please return to Anna Waldron - sealed securely in an inner-office envelope by Thursday, December 4th.

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Other Insurance Coverage

Do you or your spouse or dependent(s) maintain other health coverage? ☐**No** ☐**Yes**
Do you or your spouse or dependent(s) maintain other dental coverage? ☐**No** ☐**Yes**

Type	**Name of Insured**	**Insurance Company Name, Phone Number, and Policy Number**	**Employer**

Life Insurance Beneficiary Form (Designation of Beneficiary)

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

I herby 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

Authorization of Waiving Coverage

This is to certify that I have been given an opportunity to elect group coverage available to me and my family members through my employer and I have decided to waive my right to coverage at this time. I understand I may later enroll for medical coverage or any other coverage if my family status changes or at open enrollment. I have read and understand the requirements. I understand that it is my responsibility to report to my employer any change in my family (or individual) status. I will provide proof of other coverage by attaching a copy of my insurance card to be eligible for cash in lieu of (if applicable).

I understand that if, in the future, I wish to participate in the coverages herein declined, and I am not eligible for a special enrollment period, I and my eligible dependents will have to satisfy any late enrollment conditions that the plan may require before coverage can become effective or wait until the Plan's next Open Enrollment.

PROOF OF OTHER COVERAGE IS REQUIRED

PRINT NAME: ____________________

EMPLOYEE SIGNATURE: ____________________ **DATE:** ____________________

2015 HSA CONTRIBUTION ELECTION FORM (ADMINSTRATORS)
APPLIES TO THOSE ELECTING THE SIMPLY BLUE HDHP/HSA PLAN

Certification of HSA Eligibility

Only individuals who meet certain requirements are eligible to make or receive contributions to a health savings account (HSA). The purpose of this form is to confirm that you meet those requirements and are eligible to make and receive contributions to an HSA. Please retain a copy of this form for your tax records.

Please Note: Your employer will rely on this certification in making contributions to an HSA on your behalf. Please complete it carefully. If you have any general questions regarding the form, please contact the Benefits 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 read and initial each of the following items:

1. I have ☐**self only OR** ☐ **two person / family coverage** under the BCBS Simply Blue HDHP Plan which I understand qualifies as a "high deductible health plan" under Code § 233. *For more information see paragraph A on the back of this form.* Initial ________________
2. I cannot be claimed as a dependent on another person's federal tax return. Initial ________________
3. I am not enrolled in either Medicare Part A, Part B, Part C or Part D. Initial ________________
4. I am **not currently** covered **nor plan to enroll in** other coverage under any of the following "other" types of health coverage for the plan year 1/1/2015 – 12/31/2015:
   - 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 back of this form.* Initial ________________
   - Health care flexible spending account under my employer's benefit plan, or under my spouse's employer's benefit plan. *For more information, see paragraph C on the attached page.* Initial ________________
   - Health Reimbursement Arrangement (HRA) sponsored by any of my current or previous employer or that of my spouse. *For more information, see paragraph C on the back of this form.*
5. I understand that money from my HSA may only be used for eligible expenses incurred by myself, covered IRS tax dependents and my spouse. Initial ________________

HSA Contribution Via GCPS payroll

Per Pay / Regular Contribution	Annual Contribution	÷ Number of Pay Periods (21 or 26)	= Amount Taken Out of My Paycheck
☐ Employee HSA Deduction - fill in amount: ☐ No Employee HSA Deduction	$____________	____________	$____________
Lump Sum / One-Time Contribution ☐ Employee HSA Deduction - fill in amount: ☐ No Employee HSA Deduction	$______________ to be deducted from my first pay in January 2015		

Maximum contribution for HSA for 2015 is $3,350/Single or $6,650/Couple/Family
Catch-up Contribution (age 55+) is $1,000

GARDEN CITY PUBLIC SCHOOLS (ADMINISTRATORS)
2015 HSA CONTRIBUTION ELECTION FORM

Employee Authorization

By signing this form and returning it to my employer, I certify that all of the statements herein are true. ***I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the HSA eligibility conditions*** and I agree that if I cease to meet any of these conditions I will notify my employer's Benefit Department immediately in writing. I also understand that my own HSA contributions are subject to certain aggregate limits under federal tax law.

I authorize GCPS to deposit my contribution amount automatically to my designated Health Savings Account (HSA) each pay period beginning with the pay date indicated. This authorization will also allow GCPS to make adjustments to correct errors. I understand that this HSA contribution change is irrevocable and cannot be stopped or adjusted until I request another change in the next scheduled pay period. I also understand that I alone am responsible for the overall management of my HSA and that any tax penalties and/or bank fees that I incur are **not** the responsibility of GCPS.

____ ________________________

Employee Signature Date

___________________________ ____

Employee ID# Please Print Employee Name and Daytime Telephone Number

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 $1,300 for 2015 (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 $6,450 for 2015 (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 $2,600 for 2015 (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 $2,600 for 2015, 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 $12,900 for 2015 (as indexed for inflation).

B. Permitted non-HDHP insurance or coverage is:

- *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;
- *insurance* for a specified disease or illness (e.g., cancer insurance);
- *insurance* that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance); or
- *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:

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 and/or has any remaining balance 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.