

Enrollment/Waiver Form



Plan Year: **01-01-23** thru **12-31-23**

For Office Use Only:	Effective Date:	Date of First Deduction:	Processed By:	Date:	Annual Earnings:
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Employee Name: _____ Male ___ Female **DOB:** ___/___/___ **SS#** _____

Street Address: _____ City _____ State _____

Zip Code _____ County: _____ Home Phone: (____) _____

Email: _____ Date of Full-Time Employment ___/___/___ Occupation: _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Legally Separated **Number of Hours worked per week:** _____

Insurance Premiums

I have elected the appropriate coverage(s) listed below and agree to the following insurance premium deduction per pay period through:

- Post-Tax reduction of your salary (allows changes during the year) Pre-Tax reduction of your salary *

* If you select Pre-Tax, you cannot make election changes until next December

CHOOSE YOUR MEDICAL COVERAGES - Each plan can be elected stand-alone or you may elect multiple plans depending on your needs – electing the MEC plan avoids the individual mandate penalty. Kemper Benefits, Group# KB20527 / Anthem BCBS Group #W42910				
	MEC	Limited Medical	Drug Plan	Anthem \$4900 deductible <i>(only available to those working 30+ hours/week)</i>
Single	<input type="checkbox"/> \$8.68	<input type="checkbox"/> \$9.27	<input type="checkbox"/> \$7.08	<input type="checkbox"/> 9.12% of your weekly pay not to exceed \$89.59/week
Employee + Spouse	<input type="checkbox"/> \$11.68	<input type="checkbox"/> \$15.51	<input type="checkbox"/> \$13.63	<input type="checkbox"/> Above single cost plus \$143.10/week
Employee + Child(ren)	<input type="checkbox"/> \$10.52	<input type="checkbox"/> \$14.80	<input type="checkbox"/> \$12.04	<input type="checkbox"/> Above single cost plus \$82.19/week
Family	<input type="checkbox"/> \$13.98	<input type="checkbox"/> \$21.23	<input type="checkbox"/> \$19.30	<input type="checkbox"/> Above single cost plus \$249.30/week
<input type="checkbox"/> I Waive this coverage			<input type="checkbox"/> I Waive medical coverage for dependents only	
If you are waiving coverage, are you covered under another medical plan? ___ Yes ___ No				
If you are waiving dependent coverage, are your dependents covered under another medical plan? ___ Yes ___ No				

HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION AUTHORIZATION	
I authorize the reduction of my salary on a per paycheck basis, by the amount designated below. I understand that deductions cannot be remitted to my Health Savings Account until I have completed the HSA application and the account has been opened by the Bank.	
Per Pay Period: \$ _____	Annual Amount: \$ _____
The IRS has established annual limits that can be contributed to Health Savings Accounts. The maximum amount can be deposited into your account in the 2023 calendar year is \$3,850 for single coverage and \$7,750 for family coverage. The catch-up provision for participants age 55 and older is \$1000.	

CHOOSE YOUR DENTAL COVERAGE (Check Plan type and one coverage box only)		Kemper Benefits. Group# KB20527
<input type="checkbox"/> Single		\$3.20
<input type="checkbox"/> Employee + Spouse		\$6.40
<input type="checkbox"/> Employee + Child(ren)		\$7.01
<input type="checkbox"/> Family		\$10.21
<input type="checkbox"/> I Waive this coverage	<input type="checkbox"/> I Waive dental coverage for dependents only	

CHOOSE YOUR VISION COVERAGE (Check Plan type and one coverage box only)		Kemper Benefits. Group# KB20527
<input type="checkbox"/> Single		\$1.53
<input type="checkbox"/> Employee + Spouse		\$2.90
<input type="checkbox"/> Employee + Child(ren)		\$3.16
<input type="checkbox"/> Family		\$4.06
<input type="checkbox"/> I Waive this coverage	<input type="checkbox"/> I Waive dental coverage for dependents only	

CHOOSE YOUR SHORT TERM DISABILITY COVERAGE (Check one coverage box only)		Kemper Benefits. Group# KB20527
Weekly Benefit: 60% of salary to a maximum of \$150	<input type="checkbox"/> Age 18 - 49	\$4.40
7 day waiting period / 26 week benefit duration	<input type="checkbox"/> Age 50 - 59	\$4.98
	<input type="checkbox"/> Age 60 - 64	\$5.91
	<input type="checkbox"/> I waive this benefit	

CHOOSE YOUR ACCIDENT EXPENSE COVERAGE (Check one coverage box only)		Kemper Benefits. Group# KB20527	
	\$1,000 benefit		\$5,000 Benefit
Single	<input type="checkbox"/> \$1.86	<input type="checkbox"/>	\$4.97
Employee + Spouse	<input type="checkbox"/> \$3.71	<input type="checkbox"/>	\$10.06
Employee + Child(ren)	<input type="checkbox"/> \$4.51	<input type="checkbox"/>	\$12.70
Family	<input type="checkbox"/> \$6.52	<input type="checkbox"/>	\$18.57
		<input type="checkbox"/> I waive this benefit	

Additional worksite benefits:

CHOOSE YOUR WORKSITE COVERAGE (check one box per coverage type)		Anthem BCBS Group# W42910		
	Accident Insurance	Critical Illness- \$10,000 benefit	Critical Illness- \$20,000 benefit	Hospital Indemnity
Single	<input type="checkbox"/> \$1.77	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> \$2.49
Employee + Spouse	<input type="checkbox"/> \$2.79	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> \$5.21
Employee + Child(ren)	<input type="checkbox"/> \$2.94	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> \$3.84
Family	<input type="checkbox"/> \$4.63	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> See benefit guide for rates	<input type="checkbox"/> \$6.71
	<input type="checkbox"/> I Waive this benefit	<input type="checkbox"/> I Waive this benefit	<input type="checkbox"/> I Waive this benefit	<input type="checkbox"/> I Waive this benefit

Please complete if you are enrolling your spouse and/or children in any plan:

Dependents to be insured: (last name if different)	Relationship (Spouse/Child)	M/F	Social Security #	DOB	Add (A), Change (C), Deletion (D)			
					Medical	Dental	Vision	Accident

With regards to my salary redirections agreement and my election of benefits, I understand that:

If I elected a pre-tax deduction, I may not change elections during the plan year unless there is a change in my family status (i.e. marriage, divorce, death of my spouse or child, adoptions or birth of my child, change in job status of myself/spouse/dependent (full/part time, termination/beginning of employment), my dependents no longer eligible for insurance coverage, or a legal separation/annulment). I UNDERSTAND THAT I HAVE 30 DAYS FROM THE DATE OF ONE OF THE ABOVE OCCURRENCES TO MAKE A CHANGE IN MY PLAN. I understand that these elections do not constitute guaranteed coverage for any of the insurance listed nor does the cafeteria plan dates listed have any correlations to the effective date of insurance coverage. The administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for the benefits that are insured.

Other Health Coverage / Medicare Please check one: ___ YES ___ NO			
On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage /Medicare.			
Provide name, phone number and address of the HMO or insurance company		Policy/Certificate Number	Effective Date ____/____/____
Policy/Certificate holder's name	Social Security Number - -	Date of Birth ____/____/____	Relationship to Applicant

Printed Name: _____

Applicant Signature: _____

Date: ____/____/____