# CRISWELL AUTOMOTIVE 2024/2025 BENEFIT COVERAGE ENROLLMENT FORM

**Print Name**: _____ ☐ ***NO Plan Changes, NO Action is Required.***

**Date of Birth**: _____ **Work Site**: _____

***Notes***: **1.** **The Affordable Care Act requires everyone to be covered by medical insurance. If you are enrolled elsewhere, you must complete the declination area below.**

**2.** **The cost of Single Health Care may not exceed 8.39% of pay, for the least costly plan. Therefore, if you are enrolling in the HSA plan, as a Single participant and the costs noted below (see * below) exceed 8.39% of your pay, see Barb Menso in Human Resources to obtain your specific Medical plan rates.**

***Instructions*: For new employees, this form must be returned to Barb Menso in Human Resources no later than 45 days from your hire date**

**Check your Election option for each of the benefit coverages below. Your costs are noted next to each option. Note: If you do not check a Medical plan box, you will be enrolled in the High Deductible HSA plan, for Single coverage, if you have no coverage now. If you currently are enrolled in a plan and do not check a box, we will assume you are continuing in the same plan and coverage that you have at this time.**

## MEDICAL COVERAGE

| | | Single | Single +1 Dep | Family | Decline | |
|---|---|---|---|---|---|---|
| **1)** | **Kaiser HMO Plan** | ☐ | ☐ | ☐ | ☐ | **If you Decline Medical coverage, state reason below** |
| | Your Cost BiWeekly | **$175.39** | **$275.56** | **$400.64** | | |
| | Your Cost Monthly | **$380.00** | **$597.00** | **$868.00** | | |
| **2)** | **Kaiser Flex G Plan** | ☐ | ☐ | ☐ | ☐ | **If you Decline Medical coverage, state reason below** |
| | Your Cost BiWeekly | **$260.78** | **$440.00** | **$ 725.59** | | |
| | Your Cost Monthly | **$565.00** | **$952.00** | **$1,572.00** | | |
| **3)** | **High Deductible HSA Plan** | ☐ | ☐ | ☐ | ☐ | **If you Decline Medical coverage, state reason below** |
| | Your Cost BiWeekly | * **$166.17** | **$281.54** | **$419.08** | | |
| | Your Cost Monthly | * **$360.00** | **$610.00** | **$908.00** | | |

***If you enroll in the High Deductible HSA plan, you must open an HSA Account*. Please provide your HSA Account Number and Routing Number: *Account #*** _____ ***Routing #*** _____

**.....*See information about HSA Accounts below*.**

**4)** **I am Declining Medical Coverage. The reason I am Declining Medical Coverage is:**

☐ **Covered by Spouse plan** ☐ **Covered by Parent plan** ☐ **Covered by Other plan** ☐ **Too Costly**

☐ **Other Reason (explain)** _____

## *HSA Bank Account Information*:

If you wish to participate in the High Deductible HSA plan and receive the $100 per month Employer HSA Contribution, ***you must provide your HSA Account Number and Routing Number to Criswell H/R Department in order for deposits to be placed in your account.***

There are several banks that offer HSA accounts. You may use your bank. If your bank does not offer HSA accounts, you can open an HSA account at one of the banks listed below. ***(If you already have an HSA account, please provide your Account and Routing Number above in point 3) High Deductible HSA Plan.***

HSA Bank Options:

| | |
|---|---|
| 1) Bank of America: | 800-992-3200, To open and HSA account, choose option 1 |
| 2) Optum Bank: | 866-234-8913, say "representative", then ask rep. help you open an HSA account |
| 3) First American Bank | 866-449-1150, Press "0" for representative. Ask rep. to help you open an HSA account |



***(See 2nd Page to Complete)*** → → →

→ → → ... *Continued from Page 1*

## CRISWELL AUTOMOTIVE 2024/2025: BENEFIT COVERAGE ENROLLMENT FORM

**Print Name**: _____

### DENTAL COVERAGE

| Dental Coverage | Single | Single+1 Dep | Family | Decline |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ |
| Your Cost BiWeekly | **$27.69** | **$57.69** | **$78.47** | |
| Your Cost Monthly | **$60.00** | **$125.00** | **$170.00** | |

**If Electing *Dependent* coverage, please provide below information:**

| | Dependent's Name | Dependent's Date of Birth | Relationship | Dependent's Social Security Number |
|---|---|---|---|---|
| 1) | | | | |
| 2) | | | | |
| 3) | | | | |
| 4) | | | | |
| 5) | | | | |

### GROUP LIFE COVERAGE COVERAGE

| Group Life Coverage: | Single | Decline |
|---|---|---|
| | ☐ | ☐ |
| Your Cost BiWeekly | **$2.00** | |
| Your Cost Monthly | **$4.33** | |

***Note:*** **If you already participate in the Voluntary Life Insurance Plan, Your current enrollment will continue without interruption**

### SHORT TERM DISABILITY COVERAGE

| Short Term Disability: | Single | Decline |
|---|---|---|
| | ☐ | ☐ |
| Your Cost BiWeekly | **$11.54** | |
| Your Cost Monthly | **$25.00** | |

**Signature**: _____

**Date:** _____