2019 BENEFIT PLAN ELECTION FORM

Add additional dependents and/or update demographic information on a separate form if necessary.

Employee Coverage:

First Name:		**Last Name:**		**MI:**		**Employee #:**	
Member ID #:		**Birth date**		**Gender:**		**Marital Status:**	
Street Address:		**City:**		**State:**		**Zip:**	
Home Phone:		**Work Phone:**		**Email Address (required):**			

Member Coverage: In accordance to Patient Protection and Affordable Care Act (PPACA) regulation, you must provide your dependents social security number on this form.

Full Name:	Member ID #:	Birthdate:	Age*	Relationship	Health/RX	Dental	Optical
					☐ Yes	☐ Yes	☐ Yes
					☐ Yes	☐ Yes	☐ Yes
					☐ Yes	☐ Yes	☐ Yes
					☐ Yes	☐ Yes	☐ Yes
					☐ Yes	☐ Yes	☐ Yes
					☐ Yes	☐ Yes	☐ Yes
					☐ Yes	☐ Yes	☐ Yes

Is Your Spouse an employee of Gunnison County? If yes, please provide Name, Employee Number and Social Security Number

Name:		Employee Number:		Social Security Number:	

Do you require additional dependent ID Cards (18 years or older)?	☐ Yes ☐ No

For any child name above, is there a court order stating which parent is responsible for providing health insurance? If yes, please attach a copy of the court order or divorce decree.	☐ Attached

*Please read “Eligible criteria for dependents up to age 26” on page 4. If a dependent is disabled please provide diagnosis and the date condition developed here:

First Name:	Last Name:

SELECT YOUR PLAN: You must select only ONE plan for you and your eligible dependents

*Employee Premium rates listed are **PER PAYROLL PERIOD** and are deducted on a pre-tax basis for the following coverage period. Rates are the employees' responsibility.*

Tiers	*Traditional Plan*		*HDHP*		*Dental*		*Optical*	
Single	☐	*$ 169.62*	☐	*$ 154.34*	☐	*$ 26.12*	☐	*$ 4.56*
EE + Spouse	☐	*$ 508.86*	☐	*$ 463.03*	☐	*$ 52.23*	☐	*$ 9.32*
EE + child(ren)	☐	*$ 474.93*	☐	*$ 432.16*	☐	*$ 52.23*	☐	*$ 9.32*
Family	☐	*$ 814.18*	☐	*$ 740.91*	☐	*$ 78.34*	☐	*$ 13.54*

***☐ Opt-Out of Gunnison County Medical Coverage

*** If you elect to Opt-Out of coverage under the County's Health Plan, you must also complete the **"Do You Have Other Health Insurance Coverage?"** section of this form. By waiving coverage under this Health Plan, you also **waive** your right to COBRA continuation benefits.

***** Do You Have Other Health Insurance Coverage?**

(If you have additional coverage, you will be sent a Coordination of Benefits Questionnaire by CoreSource, to obtain all required coordination information.)

Are you or anyone named on this application covered by health insurance from another source (For example, another employer, spouse's employer or child's natural parent) ☐ Yes ☐ No	Are you or anyone named on this application entitled to Medicare? ☐ Yes ☐ No	
Name of Insured:	Employer Name of Policy Holder:	
Insurance Company Name & Address:	Group or Policy # (with insurance company):	
	Contract Type: ☐ Single or ☐ Family	Policy Effective Date:	Policy Term Date:

- **The High Deductible Plan offers you to enroll into a Health Savings Account (HSA)**
- **The Traditional and HDHP Plans offer you to enroll into a Flexible Savings Account (FSA)**
- **If you choose to Opt-Out of the health insurance you still have the option to enroll into the FSA**
- **If you choose to enroll in the HDHP and elect an FSA, the FSA will be a limited-purpose FSA which covers qualified out-of-pocket expenses for dental or vision care only**

On the next page you may elect to enroll into a Health Savings Account or Flexible Spending Account to enhance your health insurance plan. (For more information on these benefits, please refer to the Summary Plan Description (SPD).

First Name:	Last Name:

Health Savings Account (HSA)

Applies only if you have enrolled into the HDHP

HEALTH SAVINGS ACCOUNT	ANNUAL ELECTIONS Annual Maximum Contribution (includes both employee and employer contributions)
Employee	$3,500
Employee +1	$7,000
Employee + 2 or More	$7,000
To calculate your annual election for 2019, select desired amount to contribute per pay period X 12 (Pay Periods) = $ Annual Election	
☐ Health Savings Account	$ X 12 pay periods = $ Annual Election
☐ Health Savings Account Catch-up Contribution (Age 55 & Over)	$ X 12 pay periods = $ Annual Election ($1,000 / yr maximum)

It is your responsibility to monitor and maintain your Health Savings Account (funds are only available as deposited)

- Avoid penalties by using Health Savings Account monies to pay for qualified healthcare expenses only
- Retain records of all transactions for possible IRS auditing purposes
- See IRS Regulations for eligibility and participation in an HSA http://treas.gov/offices/public-affairs/hsa

Flexible Spending Account (FSA)

HDHP enrollees will be subject to a Limited Purpose FSA

FLEXIBLE SPENDING ACCOUNTS	ANNUAL ELECTIONS Annual Maximum Contribution
Health Care Reimbursement Account (HCRA)	$2,650
Dependent Care Reimbursement Account (DCRA)	$5,000
To calculate you annual election for 2019, select desired amount to contribute per pay period X 12 (Pay Periods) = $ Annual Election	
☐ HCRA	$ X 12 pay periods = $ Annual Elections
☐ DCRA	$ X 12 pay periods = $ Annual Elections

Funds deposited into my Health Care and /or Dependent Care Flexible Spending Account(s) will be available to pay for eligible expenses during the plan year. I understand I cannot change my contributions during the plan year unless I have a status change. The plan year begins January 1, 2019 and ends December 31, 2019. I will have until March 31 of the following year to submit expenses incurred during the plan year. I understand that Internal Revenue Service rules require that I forfeit unused account balances. Please refer to the Flexible Spending Account Summary Plan Description for complete details.

Employee's Signature (Do Not Print):____

Today's Date:

First Name: | Last Name:

IMPORTANT INFORMATION:

Once Gunnison County accepts your application, you and your family will be bound by the terms of the policy and the application.

AUTHORIZATION:

You appoint your employer or association to handle all matters of coverage. They may forward any agreed deductions for coverage from your wages. You are responsible for giving notice to your employer or association of changes in your status and family's status that affect coverage, such as marriage, birth or death of someone covered under the policy.
You authorize CoreSource to obtain hospital and medical records about you and your family from health care providers; and you authorize the release of any information needed to process or review a claim.

PROOF OF ELIGIBILITY:
You agree to provide proof of your dependent's eligibility for coverage when requested by CoreSource or your employer.

COURT ORDERED COVERAGE:
If you have a court order requiring you to provide coverage for a child, CoreSource or your employer may require a copy of the court order to verify eligibility and determine proper coordination of benefits. A court order includes a court approved settlement agreement.

***ELIGIBLE CRITERIA FOR DEPENDENTS UP TO AGE 26:**
You may cover children to the end of the calendar year in which they turn 26. If you have a child that is not currently covered by the plan who will be eligible for coverage under expanded definition of an Adult child, you may enroll the child for coverage effective January 1, 2019. You must notify Human Resources that you want to add the child within 30 days of the day of 2019 Open Enrollment notice, or your child will not be added. Otherwise, you will need to wait until the next year's open enrollment to add the child if he or she is still eligible at that time.

****Disabled Dependent Coverage:**

You may be eligible to obtain coverage for an unmarried child who is incapable of self-sustaining employment because of a disability that occurred before age 19. You must provide proof of the disability from a licensed physician and provide the required information to Human Resources.

Authorization:
I certify that I have carefully and fully read the information listed above regarding benefit plan coverage, the statements and answers given are complete and correct to the best of my knowledge and belief, no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Gunnison County will rely upon the completeness and truthfulness of the information given and the statements made, and if that I have made false statements or misrepresentations, or have failed to disclose any material fact, Gunnison County will be entitled to declare the benefits void and refuse all allowance of the benefits to any person under the contract. I understand that by signing and submitting this 2019 Benefit Plan Election Form, I am making a binding election as to my benefit coverage for the 2019 benefit plan year, which begins on January 1. I also understand that my election cannot be changed unless I have a qualified family status change as outlined in the Summary Plan Document and notify Human Resources within 30 days of the qualifying event. I authorize my employer to reduce my salary for the pre-tax election as indicated on this form in order to pay for the benefits I have elected.

Employee's Name: (Print)

Employee's Signature: (Do Not Print) ____

Today's Date: