BENEFIT ELECTION / PREMIUM CONFIRMATION FORM
Rates are valid for Fiscal Year July 1, 2020 through June 30, 2021

FULL NAME: First, MI, Last *(please print)*: _____ **Last 4 digits of SSN**:_____

Address:_____ **Date of Birth**: ____/____/____

THE LOCAL CHOICE (TLC) – ANTHEM MEDICAL & VISION, AND DELTA DENTAL INSURANCE (PRE-TAX)

☐ I accept coverage and authorize pre-tax payroll deductions. ***Please make a selection below.***

If enrolling or making a change to your existing TLC coverage, you must also complete, sign and return the TLC enrollment form.

**Dual Enrollment = Both eligible employees work for New Kent County*

Per Pay Deductions	**Key Advantage 250 Plan Comprehensive Dental & Vision**	**Key Advantage 500 Plan Comprehensive Dental & Vision**	**Key Advantage High Deductible Comprehensive Dental & Vision**
Employee Only	☐ $25.00	☐ $0.00	☐ $0.00
Employee + One	☐ $218.00	☐ $195.00	☐ $166.00
Employee + Family	☐ $436.00	☐ $390.00	☐ $332.50
**Dual Enrollment Spouse*	☐ $50.00	☐ $0.00	☐ $111.50
**Dual Enrollment Family*	☐ $317.75	☐ $290.00	☐ $223.00

Per Pay Deductions	**Key Advantage 250 Plan Preventative Dental & Vision**	**Key Advantage 500 Plan Preventative Dental & Vision**	**Key Advantage High Deductible Preventative Dental & Vision**
Employee Only	☐ $21.50	☐ $0.00	☐ $0.00
Employee + One	☐ $211.50	☐ $190.00	☐ $158.00
Employee + Family	☐ $426.50	☐ $380.00	☐ $316.00
**Dual Enrollment Spouse*	☐ $43.00	☐ $0.00	☐ $108.00
**Dual Enrollment Family*	☐ $309.00	☐ $280.00	☐ $216.00

☐ I decline Medical, Dental, and Vision coverage for myself and my dependents, if any. **(If declining coverage, please sign on page 2 and also complete the waiver section of the TLC enrollment form and return with this form.)**
I understand that if I decline coverage for myself, I am also declining coverage for any eligible dependents.

Please check reason for declining coverage:

☐ Do not want coverage ☐ On spouse's/parent's plan ☐ Individual Plan – Healthcare.gov/Marketplace
☐ Military ☐ Medicaid/Medicare ☐ Cobra/Retiree coverage through another group plan

FLEXIBLE SPENDING ACCOUNT (FSA) / HEALTH SAVINGS ACCOUNT (HSA) (PRE-TAX)

FSA: The 2020 FSA General & Limited Purpose Medical maximum is $2,750; the Dependent Care maximum is $5,000 if filing jointly / $2,500 if filing separately

I authorize the following Pre-Tax per pay period deductions to fund my FSA.

☐ General Purpose Medical FSA per pay period Election Amount: $_____

☐ Limited Purpose (if you're enrolled in the HDHP) per pay period Election Amount: $_____

☐ Dependent Care Flex Spending Account Annual Election Amount: $_____

HSA (High Deductible Plan ONLY): The 2020 HSA annual contribution maximum is $3,550 Individual; $7,100 EE+Dep(s); If age 55 and older, there is also a $1,000 catch up contribution. HSA maximums include both Employee and Employer contributions.

I authorize the following Pre-Tax per pay period deductions to fund my HSA.

☐ I've enrolled for the High Deductible Health Plan (HDHP). In addition to the County's HSA contribution, I wish to contribute $_____ per pay period to my Health Savings Account (HSA).

☐ I decline making any of my own HSA contributions at this time.

I **decline** or am not eligible the following: ☐ Medical FSA ☐ Dependent Care FSA ☐ HSA for HDHP

AFLAC VOLUNTARY BENEFITS (POST-TAX)

Includes Accident, Critical Illness, Short Term Disability, and Whole Life coverages. I would like to discuss/enroll the Aflac Benefits and will contact our Aflac representative Becky Smith at (804) 422-3522, or by email at aflac@smithagencyinc.com

NEW HIRES: VIRGINIA RETIREMENT SYSTEM - RETIREMENT AND LIFE INSURANCE (PRE-TAX)

New Kent County participates in the Virginia Retirement System (VRS). All full-time employees become part of the VRS Plan based on their occupation and date of hire. All full-time employees contribute 5% of their annual salary, with pre-tax deductions distributed over 24 pay periods per year. **New Hires must complete, sign, and return the VRS Beneficiary Form.**

Full-time Employees receive 100% employer paid Term Life Insurance equal to two times their annual salary, rounded to the next higher $1,000.

VRS Employee Paid Additional Term Life Insurance - Employees may elect Additional Term Life Insurance at their own expense through payroll deductions. Please contact Human Resources for Voluntary Life premiums information. If enrolling, please return your completed and signed Additional Life Insurance enrollment form.

☐ I understand that if I decline Additional Life Insurance at this time, during my New Hire eligibility period, and I choose to enroll at a later date, the coverage will require Evidence of Insurability (health questions), and I could be declined for coverage.

457 PLAN (TAX DEFERRED COMPENSATION) (PRE-TAX)

New Kent County offers a 457 Plan through VALIC that you can enroll for at any time. A 457 plan is a non-qualified, tax advantaged deferred-compensation retirement plan. If you're interested in the 457 plan or want to open an account, please contact our VALIC Representative Jason Cotton at (804) 897-5042, or by email at Jason.Cotton@aig.com. The account is established when the employee completes, signs and submits the enrollment documents to VALIC.

EMPLOYEE SIGNATURE AND AUTHORIZATION

I have been offered the above employee benefit options and I have selected my choices. I agree to allow my employer to deduct the appropriate premiums from my wages. I also understand I may not change coverage or family status unless I have a qualifying life event, or until the next July 1 annual open enrollment. (New Hires must return required forms within 30 days of hire date).

Employee Signature: _____ Date: _____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

Special Enrollment Notice and Certification – Please review and sign below if you wish to WAIVE coverage for yourself and/or any eligible dependent(s)

FULL NAME: First, MI, Last *(please print)*:_____ **Last 4 digits of SSN**:_____

Date of Birth: ____/____/____ **Address***:* _____

In addition, complete and sign the Local Choice Enrollment Form in the Waiver section and return with this form.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. **If enrolling or making a change to your existing TLC coverage, you must also complete, sign and return the TLC enrollment form.**

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement of adoption, I may be able to enroll myself and eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights now also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or you State Children's Health Insurance Program (SCHIP) coverage;
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

In the two above listed circumstances **only**, you or your dependents will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described at bullet two.

I understand that in order to request special enrollment or obtain more information, I should contact Human Resources.

Employee Signature: _____ Date: _____