**BELMONT COUNTY PERSONALIZED EMPLOYEE PLAN “ELECTION FORM”**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEPARTMENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYEE DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**INSTRUCTIONS: To elect Medical, Dental and Vision coverage, complete Sections A and E.**

 **To waive Medical Coverage, complete Sections B and E.**

 **To elect the FSA or HSA Accounts, see sections C and D.**

**SECTION A: MEDIAL PLAN ELECTIONS:**

Complete this section in its entirety, if you are electing coverage under any of the insurance plans. You have the option of choosing single or family coverage. **ALL EMPLOYEES MUST COMPLETE THIS ENROLLMENT FORM.** Your medical plan choice is CEBCO/Anthem Blue Cross-Blue Shield. You pay a portion of the cost of your medical coverage. Cost is based upon whether you enroll as single or family coverage. Payroll deductions for medical coverage are on a pre-tax basis. You may change your election during the plan year ONLY if you have a family status change as defined by the plan.

**TO ELECT INSURANCE COVERAGE:** If you are electing medical, dental and vision coverage, check either single or family coverage next to the plan you want. Then complete the Dependent Information and Additional Coverage information below. **Go to section E.**

**(1)CEBCO/Anthem BC-BS (2)CEBCO/Anthem BC-BS-HSA Plan Option 2**

**\_\_\_\_\_\_\_Single Coverage Only \_\_\_\_\_\_\_\_Single Coverage Only**

**\_\_\_\_\_\_\_Family Coverage \_\_\_\_\_\_\_\_Family Coverage**

 **(3)VISION SERVICE PLAN (4)DELTA DENTAL PLAN**

 **\_\_\_\_\_\_\_Single Coverage Only \_\_\_\_\_\_\_Single Coverage Only**

 **\_\_\_\_\_\_\_Family Coverage \_\_\_\_\_\_\_Family Coverage**

 **\_\_\_\_\_\_\_NO COVERAGE \_\_\_\_\_\_\_NO COVERAGE**

**NOTE:** If you waive coverage on the vision and /or dental plans, you will not be eligible to participate until the next enrollment period.

**DEPENDENT INFORMATION**: Enter the information below for any dependents you are enrolling in the medical plans including dental & vision.

**LNAME FNAME RELATIONSHIP D.O.B. SOCIAL SECURITY #**

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**ADDITIONAL COVERAGE**: If you elected one of Belmont County’s medical plans and you or your dependents are covered under another employer-sponsored plan, please provide the name of the employer, the insurance company and the policy number below.

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE CO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION B: TO WAIVE MEDICAL COVERAGE**

If you are waiving coverage for cash, check the box below and complete the information on Other Coverage. You will still need to complete the front of the “Election Form”

**Go to Section E.**

**Remember when waiving medical coverage:**

**(1) You must be covered under another employer-sponsored plan, and**

**(2) You may not change your election during the plan year unless you have a family status change, as defined by the plan.**

**(3) The cash you receive is taxable income to you.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I ELECT TO WAIVE MEDICAL & PRESCRIPTION DRUG COVERAGE**

**OTHER COVERAGE: Provide the following information on the other employer-sponsored medical plan through which you have coverage.**

**EMPLOYER INSURANCE COMPANY POLICY NUMBER**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION C: FLEXIBLE SPENDING ACCOUNT (FSA)**

Participating in the Flexible Spending Account is entirely up to you. If you choose to participate, you will need to complete the Flexible Spending Account Enrollment Form included in your packet along with the amounts allowed and guidelines.

**SECTION D: HEALTH SAVINGS ACCOUNT (HSA) OPTION 2 PLAN ONLY**

A Health Savings Account is an account that you can put money into to save for future medical expenses. Contributions can be made but you must meet the guidelines to be eligible to enroll in an HSA account. A form will be included in your packet to inform you of all the guidelines to qualify and complete.

**NOTE: YOU CANNOT DO THE FLEXIBLE SPENDING ACCOUNT IF YOU CHOOSE THE HSA ACCOUNT**

**SECTION E: AUTHORIZATION**

**THIS SECTION MUST BE COMPLETED BY ALL EMPLOYEES, REGARDLESS OF THE ELECTIONS MADE.**

I have read and understand the statements on this election form and the descriptive materials made available on the Belmont County Personalized Employee Plan. If I have elected family coverage, the Health Savings Account or the Flexible Spending Account, I agree to have Belmont County reduce my salary in an amount equal to the contributions I have elected.

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**SIGNATURE DATE**

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**DEPARTMENT**