Payroll Deduction Authorization

February 1st, 2018 – January 31st, 2019

Employee Name: _____

This form must be completed by all employees and returned to HR.

You must indicate in section A, B, and C if you are electing or waiving the described benefit.

A. 2018-2019 MEDICAL Plan Options (Contributions will be taken Bi-Weekly on a PRE-TAX BASIS.)

	Trio HMO	Access + HMO	HSA PPO	Full PPO
Single	❑ $37.95	❑ $102.03	❑ $100.68	❑ $205.75
Employee + Spouse	❑ $328.14	❑ $475.52	❑ $472.43	❑ $714.09
Employee + Child(ren)	❑ $194.21	❑ $303.14	❑ $300.86	❑ $479.47
Employee + Family	❑ $462.08	❑ $647.90	❑ $644.01	❑ $948.71

Waiving Medical Coverage

❑ I elect to WAIVE Medical coverage for benefit period 02/01/2018 – 01/3012019 and I understand that I may not enroll mid-year unless I have a qualifying life event.

B. 2018-2019 DENTAL Plan Options (Contributions noted below will be taken Bi-Weekly on a PRE-TAX BASIS.)

	Dental DHMO	Dental PPO
Single	❑ $1.46	❑ $19.30
Employee + Spouse	❑ $10.44	❑ $46.91
Employee + Child(ren)	❑ $12.19	❑ $52.31
Employee + Family	❑ $23.90	❑ $88.36

Waiving Dental Coverage

❑ I elect to WAIVE Dental coverage for benefit period 02/01/2018 – 01/3012019 and I understand that I may not enroll mid-year unless I have a qualifying life event.

C. 2018-2019 VISION Plan Option (Contributions noted below will be taken Bi-Weekly on a PRE-TAX BASIS.)

	Vision Plan
Single	❑ $0.59
Employee + Spouse	❑ $4.80
Employee + Child(ren)	❑ $3.50
Employee + Family	❑ $7.89

Waiving Vision Coverage

❑ I elect to WAIVE Vision coverage for benefit period 02/01/2018 – 01/3012019 and I understand that I may not enroll mid-year unless I have a qualifying life event.

Payroll Authorization and Acknowledgements

I, the undersigned employee, authorize Office Solutions to deduct the appropriate amount(s) as a payroll deduction from the pre-tax earnings payable to me each pay period for benefits coverage as elected above. By checking any of the above boxes, your portion of the items listed above will automatically carry over from year to year until and unless you notify the Plan Administrator by completing another election form declining participation. Any changes will be effective as of the first day of the next plan year. The salary reduction amounts for the carry-over election will be adjusted automatically to reflect any increase or decrease in the cost of premiums. This election applies to any line of insurance selected above.

I also understand that I cannot change my enrollment for Medical, Dental, or Vision during the benefit plan year (February 1st through January 31st) unless the Plan Administrator determines that I have a qualifying life event and that the requested change is necessitated by and consistent with that life event. If I experience such a life event, I will notify the Human Resources Department within 30 days of the event date. I understand if I do not provide such a written notice within the required time frame, I will not be eligible to make the change until the next open enrollment period.

_____

Signature Date