STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

APPLICATION/POLICY CHANGE/TERMINATION

(Please use Blue or Black Ink Only)

ENROLLEE: Policy Change ____ New Enrollee ____ Termination ____ **EFFECTIVE DATE:** __________

Employee's Last Name First Name MI

Street Address City State Zip Code Phone

Hire Date (mo/day/yr) ____/____/____ Sex ____Male ____Female Employee's Social Security #__________________

Employee Date of Birth (m/day/yr) ____/____/____ Marital Status___Single ___Married ___Divorced ___Widowed

Date Married: (month/day/year) ____/____/____

INSURANCE DESIRED:

HEALTH

SUPERMED PLUS PPO —418470-______ ____**Single** ____**Family**

AULTCARE PPO—21804M -______ ____**Single** ____**Family**

BRONZE PLAN—418470-______ ____**Single** ____**Family**

DENTAL —418470______ ____**Single** ____**Family**

VISION—418470______ ____**Single** ____**Family**

CHANGES: Name(s) of Member/Dependents to be Changed/Added/Termed______________________________

ADD DUE TO: Marriage____ Birth____ Adoption____

TERMINATE DUE TO: Divorce____ Left Employ____ Ineligible____ Request Cancel____ Death____ Date of Death________

Relationship Child/ Spouse	Birthdate Mo/Day/Yr	Sex M/F	Last Name (Only if Different)	First Name	Social Security #	Over Age Status Full-Time** Student	Over Age Status Disabled

**Completed Adult Dependent Certification Form required for dependent child between 19 and 26 for Dental and/or Vision coverage.

MEDICARE INFORMATION

Are you covered by Medicare? ____Yes ____No If YES, Medicare #___________ Effective Date__________ __Hemodialysis

Is your spouse covered by Medicare? ____Yes ____No If YES, Medicare #___________ Effective Date__________ __Hemodialysis

OTHER INSURANCE INFORMATION

Do you or any of your family members have other health/dental insurance? ____YES ____NO

If YES, employed by:______________________________ ____ACTIVE ____RETIRED

Names of Insured:______________________________

Name of Insurance Carrier______________________________

Address______________________________ Policy No.______________ ____Single ____Family

When did this insurance become effective?____________________

TERMS AND CONDITIONS: Your signature on this form will indicate your understanding that your employer will enroll you for all group health plan coverages for which you are eligible and will constitute your authorization to your employer or any of its agents to release to all administrators, carrier, or health care coverage organizations, as applicable, the information contained on this form.

Each dependent listed on this form must be an eligible dependent in accordance with your group health care plan.

Your signature on this form constitutes your authorization to any health care coverage carrier, organization, employer Medicare-approved organization, or provider of services to release any information necessary to process a claim.

SIGNATURE______________________________ Date__________

Employer Representative______________________ Date__________ Notes:______________________

EMPLOYER'S HOSPITALIZATION/DENTAL/ADDITIONAL LIFE INSURANCE DEDUCTION AUTHORIZATION

NAME____________________ S.S.#____________________

ADDITIONAL LIFE INSURANCE

$ 5,000 - $ .98 per month	____	$35,000 - $6.83 per month	____
$10,000 - $1.95 per month	____	$40,000 - $7.80 per month	____
$15,000 - $2.93 per month	____	$45,000 - $8.78 per month	____
$20,000 - $3.90 per month	____	$50,000 - $9.75 per month	____
$25,000 - $4.88 per month	____	$55,000 - $10.73 per month	____
$30,000 - $5.85. per month	____	$60,000 - $11.70 per month	____

Additional life insurance must be purchased within 30 days of hire. If you wait be beyond 30 days, you will be required to show proof of insurability and you must wait until the next reenrollment period (September of each year).

(TO BE DEDUCTED BETWEEN THE FIRST AND SECOND PAYS OF THE MONTH.)

MONTHLY EMPLOYEE SHARE

Health	- Family - $280.96 per month	____
	- Single - $115.66 per month	____
Dental	- Family - $ 46.11 per month	____
	- Single - $ 18.69 per month	____
Bronze Plan – Health	- Family - $ 1,259.23 per month	____
	- Single - $ 518.37 per month	____

(TO BE DEDUCTED BETWEEN THE FIRST AND SECOND PAYS OF THE MONTH.)

I elect not to carry Dental. ____
I elect not to carry Health. ____

If you elect not to enroll in Health Insurance Coverage, please sign the Waiver of Coverage Form that is included in your packet.

Note: **The current monthly amount is based on premiums as of July 1, 2020 and will change with annual premium updates each July.**

____________________ ____________________

Signature **Date**

EMPLOYEE ENROLLMENT FORM
Flexible Spending Account (FSA)

Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected.
Return the completed and signed form to your employer for processing.

For Employer to complete where applicable:

Employer Name ______	Employer TASC ID # ______
Employer Class ______	Employer Division ______
Participant Plan Effective Date ______	First Payroll Date ______

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		MI:		Last Name:	
TASC ID # (if known):		Email Address[1]:			
Primary Phone #:		Mobile Phone #[1]:			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:		+4
Date of Birth:		Hire Date:		Payroll Frequency:	

All fields are required for account setup. Information is confidential and is not used for marketing purposes.
[1]Please provide this information if available (not required).

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2 and 3.

I select the following benefits and amount(s) to be deducted pretax:	Employee Annual Salary Reduction Election Amount	EMPLOYER Annual Contribution	Maximum Employee Annual Election
☐ **Healthcare FSA** ☐ I elect to exclude my spouse (for HSA eligibility reasons).	$	$	$
☐ **Limited Purpose Healthcare FSA**	$	$	$
☐ **Dependent Care FSA** (Daycare Expenses)	$	$	$
☐ **Healthcare Premium (NESP) Reimbursement Account**	$	$	$

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.
To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** (No fee)	
2	**Dependent Name (First, MI, Last):** (Additional fee may apply)	
3	**Dependent Name (First, MI, Last):** (Additional fee may apply)	

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose
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EMPLOYEE ENROLLMENT FORM

Flexible Spending Account (FSA)

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature: ______________________________ Date: ______________

ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable benefit account type:

1. **Healthcare FSA Election:** The amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental, orthodontic, and eye care expenses. Participants may elect a maximum based on the current IRS limits. Your employer's plan maximum may be less than the IRS maximum. Review your Summary Plan Description (SPD) for your specific plan maximum. Your election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement of eligible expenses on the first day of the plan year.
2. **Limited Purpose Healthcare FSA Election:** Amount you expect to pay out-of-pocket for dental and vision expenses throughout the plan year. Your total election amount is available on the first day of the plan year as expenses are incurred. Refer to your SPD for your specific plan maximum.
3. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the Plan Year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single. Plan funds are available as they are contributed.
4. **Non-Employer Sponsored Premium (NESP) Election:** The total annual out-of-pocket cost for privately purchased (individual) insurance *premiums* such as health, disability, and cancer insurance. Other medical expenses are not eligible under the NESP Plan. Examples of insurance premiums NOT eligible are employer-sponsored group insurance (premiums deducted from your paycheck or your spouse's paycheck), life insurance, long-term care insurance, and premiums for coverage under the federal exchange "Marketplace" program. Please note, when disability premiums are pretaxed, the benefits received are taxable. NESP is not subject to contribution limits unless otherwise set by your employer but is subject to the 'Use it or Lose it' rule in which unused funds are forfeited at year-end. Plan funds are available as they are contributed.

IMPORTANT NOTE:

How Cafeteria Plans affect Social Security Benefits: Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs available under an FSA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.

For enrollment assistance: call toll-free 800-422-4661
Have your enrollment form, employer name, and the Client ID# ready.
Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits/

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose
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