BENEFITS ENROLLMENT FORM - 52 pay

Salary Redirection Agreement
Plan Year Beginning 8/1/2023

- ❑ Annual Enrollment
- ❑ New Enrollment
- ❑ Reinstatement
- ❑ Add Dependent
- ❑ Cancel Dependent
- ❑ Beneficiary Change
- ❑ Name Change
- ❑ Change in Coverage

Effective Date of Enrollment and/or Change: ________________

PCP NUMBER (HMO only)

PERSONAL DATA

EMPLOYEE NAME (Last, First, MI)		SOCIAL SECURITY NUMBER	
HOME STREET	HOME CITY	HOME STATE	HOME ZIP
GENDER ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed	DATE OF BIRTH	DATE OF HIRE

DEPENDENT INFORMATION

Name (Last, First, MI)	Relationship	Social Security Number	Birth Date mm/dd/yyyy	Gender	PCP number (HMO only)
	Spouse			❑ Male ❑ Female	
	Child			❑ Male ❑ Female	
	Child			❑ Male ❑ Female	
	Child			❑ Male ❑ Female	
	Child			❑ Male ❑ Female	

BENEFIT ELECTION & WEEKLY PAYROLL DEDUCTIONS (52 PAY PERIODS)

❑ I **ELECT** Medical Coverage

❑ I **DECLINE** Medical Coverage
Reason for Declination: ❑ I have other coverage ❑ Other

Plan	Employee Only	Employee & Spouse	Employee & Child	Employee & Family
MTBCP026 PPO copay	❑ $139.27	❑ $244.33	❑ $235.93	❑ $340.99
MTBCP007H PPO HSA	❑ $99.17	❑ $180.40	❑ $173.91	❑ $255.13
MTBAB024 HMO copay	❑ $96.07	❑ $175.46	❑ $169.11	❑ $248.50
MTBAB301H HMO HSA	❑ $47.88	❑ $98.61	❑ $94.68	❑ $145.30
Dental Plan	❑ $8.62	❑ $16.55	❑ $17.97	❑ $25.67

EMPLOYEE NAME (Last, First, MI)	SOCIAL SECURITY NUMBER

HEALTH SAVINGS ACCOUNT CONTRIBUTION (only available if enrolled in HSA Plan)

Plan	Election
2023 HSA contribution limit is $3,850 for individual coverage and $7,750 for dependent coverage.	Monthly amount $________________
Catchup Contribution Available if over age 55. Annual limit is an additional $1,000	Monthly amount $________________

AUTHORIZATION and CERTIFICATION

With this benefit election form, I hereby authorize my employer to make deductions from my paycheck on a **Pre-Tax basis**.
I understand that certain non-medical coverages may not be eligible for pre-tax deductions.

I understand that if my elections are taken on a **pre-tax** basis that:

- I cannot change this election during the plan year unless I have a Qualifying Event as defined by IRS Section 125.
- My employer may reduce or cancel this pre-tax election, if necessary, to comply with provisions of the Internal Revenue Code.
- If required contributions for elected benefits are increased or decreased, my pay redirection will be adjusted to reflect that increase or decrease.
- I understand that if I have agreed to have my deductions taken on a pre-tax basis, these amounts will not be subject to Social Security or Federal Income Tax withholding which may result in a reduction of future Social Security benefits to which I may be entitled.
- If I do not complete and return a new benefit enrollment form during my open enrollment period, my current benefit elections will continue to be effective for the new plan year.

I represent that the information I have provided on this enrollment form is complete, true and accurate to the best of my knowledge. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage.

EMPLOYEE NAME (PRINT)	EMPLOYEE SIGNATURE	DATE