Rochester Community Schools – Directors

2024 Election Form – Plan Year: January 1, 2024 – December 31, 2024

Complete only if you are making changes, newly enrolling, opting-out of medical or contributing to a Flexible Spending Account
You must complete all sections of this form, regardless if you are already covered under the plan

EMPLOYEE INFORMATION

1

Name _____ DEN# _____
First Middle Initial Last

Address _____ Date of Hire _____
Street City State Zip Code

Email _____ Phone _____ ❑ **Check box if address has changed from previous year**

Date of Birth _____ ❑ Male ❑ Female Work Location _____ # Pays (26) _____

DEPENDENT INFORMATION - List those individuals to be covered under the Medical, Dental and/or Vision Plans

2

	LAST NAME	FIRST	GENDER	BIRTHDATE	MEDICAL	DENTAL	VISION
Spouse					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
Child					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
Child					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
Child					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
Child					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
Child					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop

BENEFIT SELECTIONS

3

Medical Plan - Blue Cross Blue Shield of Michigan

Choose **one** of the following options

BCBSM PPO Medical Plan	**Per Pay – 26 Pay Cycle**
❑ Single	$65.77
❑ Single + 1	$157.85
❑ Family	$197.32
BCBSM HSA Medical Plan	**Per Pay – 26 Pay Cycle**
❑ Single	$58.32
❑ Single + 1	$137.50
❑ Family	$168.80

OPT-OUT OF MEDICAL COVERAGE

❑ Opt-Out - Taxable Income (Complete the Opt-Out Attestation of Other Coverage below)
If you choose to decline medical coverage, your opt-out incentive will be $150 per month. The opt-out incentive will be distributed as taxable income. This amount will be taxed for federal, state, and Social Security.

3a

Opt-Out Attestation of Other Coverage - Please read and sign below

If you or your dependents are enrolled in other coverage, you and your dependents may not enroll under our medical plan. In accordance with the union agreements, the school district will not provide dual and/or coordinated coverage.

I understand my right to enroll for coverage for my eligible dependents and me. However, I have other coverage available to me for the plan year January 1, 2024 through December 31, 2024, and so I would like to waive coverage under the District's medical plan. I choose to decline medical and prescription drug coverage offered by Rochester Community Schools. By signing below, I attest I understand that the Patient Protection and Affordable Care Act, also called Health Care Reform requires most individuals to have health insurance or pay a penalty for non-compliance. All members of my Tax Family have or will have Minimum Essential Coverage for the entire plan year, January 1, 2024 through December 31, 2024. "Tax Family" includes you and all other individuals you reasonably expect to claim a personal exemption deduction for the taxable year or years covered by the opt-out time period. "Minimum Essential Coverage" is medical coverage that meets minimum standards under the Affordable Care Act. It does not include coverage purchased in the individual market, whether or not obtained through the Marketplace. I understand that I will have an opportunity to enroll for medical and prescription drug coverage during the next annual benefit enrollment period, or I may enroll for coverage before then if I qualify for a special enrollment period or have a qualifying change in status. I understand that to enroll for coverage during a special enrollment period or due to a qualifying change in status, I must request coverage from my employer within 30 days of the event. I understand that this Attestation is required annually to continue and I affirm the information I am providing is true and accurate to the best of my knowledge.

⇨ **Signature** _____ **Date** _____

Employee Name_____

4 Dental and Vision Plans - Blue Cross Blue Shield of Michigan

If you enroll in medical coverage, you will automatically be enrolled in the same dental and vision coverage tier as your medical election

If you opt-out of medical coverage, choose **one** of the following options

BCBSM Dental and Vision Plans	**Per Pay – 26 Pay Cycle**
❑ Single	$0.00
❑ Single + 1	$0.00
❑ Family	$0.00

5 Flexible Spending Accounts - Basic and Health Savings Account (HSA):

	Maximum Annual Elections	Annual Election	Pay Period Frequency	Per Pay Amount
Health Care FSA	$3,200	$_____	26	$_____
-Limited FSA if enrolling in the HDHP				
Dependent Care FSA	$5,000	$_____	26	$_____
Health Savings Account	$4,150 for single $8,300 for family	$_____	26	$_____
-Only available with HSA Medical Plan	(minus any money contributed by Rochester Schools)	*Rochester Schools will contribute $800 for single coverage or $1,600 for family coverage if you enroll yourself and your dependent(s) in the HSA medical plan*		

6 Life and Accidental Death and Dismemberment – The Standard

You must complete a Statement of Health, found on the Rochester Community Schools website, if your Optional Life/AD&D election is subject to evidence of insurability as detailed in the Benefit Guide

Basic Life and AD&D Plan - Rochester Schools provides Life and AD&D insurance of $50,000 if you enroll in medical; or, $100,000 if you opt-out of medical

Optional Life and AD&D Plan: You must elect for employee before spouse coverage can be elected

❑ **Employee** – may purchase Optional Life and AD&D insurance in increments of $10,000 up to $500,000, enter your election in the table below & calculate your cost

$_____ / $1,000 X $ _____ = _____

Must evenly divide $10,000 *Rate (Table)* *Cost per month*

❑ **Spouse** – may purchase Optional Life and AD&D insurance in increments of $10,000 up to $150,000, enter your election in the table below & calculate your cost

$_____ / $1,000 X $ _____ = _____

Must evenly divide $10,000 *Rate (Table)* *Cost per month*

Optional Life/AD&D Table

Monthly cost per $1,000

Age	Employee	Spouse
Under 25	$0.055	$0.065
25 – 29	$0.055	$0.075
30 – 34	$0.065	$0.095
35 – 39	$0.085	$0.105
40 – 44	$0.105	$0.125
45 – 49	$0.155	$0.185
50 – 54	$0.245	$0.325
55 – 59	$0.405	$0.525
60 – 64	$0.565	$0.945
65 – 69	$1.005	$1.605
70+	$1.625	N/A

❑ **Children** – may purchase Optional Life and AD&D insurance in increments of $2,500 up to $10,000, circle your election & cost below

$2,500	$ 0.54	$7,500	$ 1.61
$5,000	$ 1.08	$10,000	$ 2.15

BENEFICIARY INFORMATION - If you want to change or update your beneficiary, please complete a The Standard Beneficiary form found on the Rochester Community Schools website

7 SIGNATURE - Please read and sign below

I wish to make the choices indicated on this form and authorize Rochester Community Schools to make any necessary pre-tax or after-tax payroll adjustments. I understand that these elections are effective January 1, 2024 through December 31, 2024. I understand that I am required to reimburse Rochester Community Schools for all elected benefits either during or after any authorized leave. I understand that Rochester Community Schools retains the right to amend, modify, or terminate this Plan at any time.

I understand that pre-tax contributions will slightly impact my social security contributions. I understand that I need to use any dollars I've deposited in the Health Care and Dependent Care Reimbursement Accounts by year-end or they will be forfeited. Adjustments may be necessary to comply with IRS discrimination tests. I am aware that the plan maximum may be reduced to maintain compliance with IRS regulations.

I understand that this election is irrevocable until next plan year unless there is an allowable change in family status that occurs and I notify Department of Human Resources within 30 days of the allowable change. I certify the information on this form is complete and accurate. Any person who, with intent to defraud or knowing that they are facilitating a fraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I understand there shall be no duplication of hospitalization benefit. I must notify the Department of Human Resources of any personal, duplicated benefit coverage – either through personal coverage or coverage from spouse's or family's benefit plan. If I am covered by any other duplicated hospitalization benefit, the Employer's obligations under this benefit shall be waived.

⇨ **Signature** _____ **Date** _____