

Garrison Forest School

2026 Enrollment Form

Instructions

- Step 1:** Complete the **Employee Information** section. All information is required.
- Step 2:** Complete the **Benefit Elections** section. Be sure to indicate both Plan and Coverage Level selections for Medical, Dental and Vision benefits.
- Step 3:** Complete **Dependent Information** section for those Dependents covered under the plan. All information is required.
- Step 4:** If you have chosen to participate in the HSA Plan and you would like to make contributions to a Health Savings Account, complete the **HSA Contribution** section.
- Step 5:** Review and sign the **Signatures** section. Be sure to sign both sections if you are electing to contribute to an HSA.

Employee Information

Name:	SSN:
Address:	Date of Birth:
	Gender: ☐ Male ☐ Female
Phone Number:	Date of Hire:
Email Address:	Status: ☐ Full Time ☐ Part Time
Benefits Effective Date:	Marital Status: ☐ Single ☐ Married
Salary: (only applicable if offering ancillary)	Payroll Frequency: Semi-Monthly 24 pays School State & Zip Code: MD & 21117

Type of Action

☐ ENROLL ☐ Open Enrollment ☐ Newly Benefit Eligible ☐ Return from Leave of Absence ☐ Other _____	☐ CANCEL COVERAGE ☐ No longer benefit eligible ☐ Marriage- Drop Employee-joining spouse's plan ☐ Spouse newly employed/eligible for coverage through a spouse's plan ☐ Open enrollment through spouse's employment adds coverage ☐ Newly Eligible for Medicare or Medicaid ☐ Leave of Absence ☐ Retirement ☐ Termination ☐ Death ☐ Other _____	☐ ADD DEPENDENTS ☐ Marriage – Add Spouse and Employee/Children ☐ Divorce – Add Employee/Child ☐ Birth or Adoption of Child ☐ Loss of Employment ☐ Open enrollment through spouse's employment drops coverage ☐ Loss of Medicare, Medicaid, or CHIP Eligibility ☐ Change in Status to Benefit Eligible Employee ☐ Other _____	☐ CANCEL DEPENDENT(S) ☐ Marriage- joining spouse's plan ☐ Divorce- Drop Spouse ☐ Dependent attained age 26 ☐ Spouse newly employed/eligible for coverage through a spouse's plan ☐ Open enrollment through spouse's employment adds coverage ☐ Newly Eligible for Medicare or Medicaid ☐ Other _____
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Medical Plan Election		Dental Plan Election			Vision Plan Election	
<u>Cigna</u> ☐ Core HSA ☐ Premium HSA ☐ PPO ☐ Decline	<u>Kaiser</u> ☐ Signature HMO ☐ Decline	<u>Cigna</u> ☐ PPO 2500 MAC ☐ PPO 5500 MAC ☐ Decline	<u>Dominion</u> ☐ Elite Plus ePPO ☐ Decline	<u>VSP</u> ☐ VSP Vision ☐ Decline		
☐ Individual ☐ Parent + Child(ren) ☐ Employee + Spouse ☐ Family	☐ Individual ☐ Parent + Child(ren) ☐ Employee + Spouse ☐ Family	☐ Individual ☐ Parent + Child(ren) ☐ Employee + Spouse ☐ Family	☐ Individual ☐ Parent + ONE Child ☐ Employee + Spouse ☐ Family	☐ Individual ☐ Parent + Child(ren) ☐ Employee + Spouse ☐ Family		
Dependent Information						
Name	Social Security Number	Gender	Relationship	Date of Birth	Add or Remove	Check Benefits to Cover
		☐ M ☐ F			☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision
		☐ M ☐ F			☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision
Reliance Group Accident Insurance						
Plan A (Low)			Plan B (High)			
☐ Individual ☐ Parent + Child(ren) ☐ Employee + Spouse ☐ Family ☐ Decline			☐ Individual ☐ Parent + Child(ren) ☐ Employee + Spouse ☐ Family ☐ Decline			
Reliance Group Critical Illness Insurance						
Employee		Spouse		Child(ren)		
☐ \$5,000 ☐ \$10,000 ☐ \$15,000 ☐ \$20,000 ☐ Decline		☐ \$5,000* ☐ \$10,000* ☐ \$15,000* ☐ \$20,000* ☐ Decline		☐ 25% of Employee Amount ☐ Decline		
*Not to exceed 100% of employee amount						

Health Savings Account (HSA) Eligibility

In order to establish a Health Savings Account (HSA), you must be classified as an eligible individual under IRC Section 223, applicable sub-sections and rulings, collectively called the "Code". You are eligible to participate ONLY if you meet the following requirements:

- (1) You are covered by a High Deductible Health Plan (HDHP) AND
- (2) You are NOT COVERED by another health plan that is not a HDHP (including a general purpose FSA set up by you or your spouse) AND
- (3) You are not able to be claimed as a dependent by another taxpayer AND
- (4) You are not entitled to benefits under Medicare

Health Savings Account (HSA) Contributions*

***ONLY COMPLETE THIS SECTION IF YOU WISH TO ADD A MONETARY HSA CONTRIBUTION FROM YOUR PAYCHECK.**

I ELECT A PER PAY CONTRIBUTION OF \$_____ TO MY HSA EFFECTIVE _____

**DO NOT INCLUDE ANY EMPLOYER CONTRIBUTIONS IN THE ELECTION AMOUNT ABOVE.
CONTRIBUTION AMOUNTS MAY NOT EXCEED LIMITS LISTED BELOW.**

2026 Maximum Contribution Amount

The annual contribution amount, including employer funding, may not exceed **\$4,400.00** for individual coverage or **\$8,750.00** for all other coverage levels. Individuals **age 55 and older** can make a catch-up contribution of **\$1000.00** for each year until enrolling in Medicare.

Note: If you are a current MSA or HSA holder with an account at another financial institution, please remember that the total annual contributions to all accounts may not exceed federally mandated limits.

Signatures

Health Plan Elections

☐ I hereby request the above elections for myself and my eligible dependents. I agree to the terms specified in any applicable health benefits certificate or other official description of the terms of my elected plans. **I AUTHORIZE my employer to DEDUCT from my earnings the amount required to participate in the elected plans indicated on this form.**

☐ I understand that my share of eligible (medical/dental/vision) group premium(s) will be automatically deducted pre-tax. I understand that if I do not want eligible premiums to be deducted pre-tax and prefer to be taxed on these dollars, I will contact the Benefits Administrator.

☐ I elect to waive coverage as indicated above and I understand that, if I decide at a later date that I want any of the coverages for which I or my dependents are now eligible, but which I declined, I will have to wait until the next open enrollment period unless I am changing my elections on account of and consistent with a family status change within the meaning of the Internal Revenue Code section 125.

Employee Signature: _____ Date: _____

HSA Contributions

I authorize my employer to make the appropriate payroll deductions for the contribution I have elected above.

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the IRS Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. **I further understand that I am responsible for ensuring that all contributions made to my HSA do not exceed the annual maximum allowed by the IRS.**

Employee Signature: _____ Date: _____