



Name

Location

July 1, 2026-June 30, 2027 Plan Election and Premium Confirmation Form

The Local Choice MEDICAL INSURANCE (DENTAL & VISION INCLUDED)

- ☐ I accept coverage and authorize payroll deductions. **Please make selection below .**
- ☐ I decline Medical coverage. **Please check reason for declining coverage .**
- ☐ On Spouse's Plan ☐ Medicare / Medicaid ☐ Don't want coverage
- ☐ On Individual Plan ☐ Healthcare.gov / Marketplace ☐ Military
- ☐ New Hire

Payroll Deductions (per payroll)	The Local Choice HDHP \$3400/20%/5000		The Local Choice Key Advantage \$1000/20%/5000		Monthly Cost	
					HSA Plan	\$1K Plan
Employee Only		\$0.00		\$84.55	\$0.00	\$169.10
Employee + Spouse		\$268.74		\$408.55	\$537.47	\$817.10
Emp + Spouse (2 EE's)		\$0.00		\$106.20	\$0.00	\$212.40
Employee + Child		\$101.40		\$323.21	\$202.80	\$646.42
Employee + Children		\$101.40		\$323.21	\$202.80	\$646.42
Employee + Family		\$469.38		\$732.01	\$938.75	\$1,464.02
Emp. + Family (2 EE's)		\$0.00		\$571.06	\$0.00	\$1,142.12

HealthEquity Health Savings Account (HSA) *Must make an election even if currently enrolled

- ☐ Employer AND Employee funded - please create an account for me. I understand I must complete carrier enrollment.
- ☐ I decline this account.

HealthEquity FLEXIBLE SPENDING ACCOUNT (FSA) *Must make an election even if currently enrolled

- ☐ Employee paid - please ENROLL me in this account. I understand I must complete the carrier enrollment.
- ☐ I decline Voluntary Employee Paid FSA benefits.

AFLAC (ACCIDENT/CRITICAL ILLNESS/HOSPITAL INDEMNITY)

- ☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment.
Please see HR for rates and forms.
- ☐ I decline Voluntary Employee Paid Benefits.

MASSMUTUAL (GROUP WHOLE LIFE INSURANCE)

- ☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment AND Evidence of Insurability forms, and must be approved through their underwriting process before the benefit will begin. **Please see HR for rates and forms.**
- ☐ I decline Voluntary Employee Paid Benefits.

I have been offered the above employee benefit options and I have selected my choices. I agree to allow my employer to deduct the appropriate premium(s) from my wages. I also understand I may not change coverage or family status unless I have a qualifying event or until the next open enrollment.

Signature

Date