accupac

All Accupac employees must complete this form and submit to Human Resources

2023 Enrollment / Change Form

PLEASE PRINT

Please check all that apply: ☐ Open Enrollment ☐ New Hire Enrollment

☐ Drop Coverage ☐ Add/Delete Dependent ☐ Change Address

Please check which benefits you are electing: ☐ Medical ☐ Dental ☐ Vision ☐ HSA/FSA ☐ Supplemental Life

Please check which benefits you are waiving: ☐ Medical ☐ Dental ☐ Vision ☐ HSA/FSA ☐ Supplemental Life

Section A – Employee Information

Name (Last, First, MI) _____ Facility Location_____

Home Address – Street_____

City_____State_____Zip_____

Social Security # _____ Date of Birth _____Date of Hire _____Employee #_____

Gender_____ Marital Status (Single, Married, Divorced, Widowed, Separated) _____

Cell Phone_____ Home Phone _____

Accupac occasionally needs to send legal notifications to plan participants. We may send them to you via email. I understand that by providing my email address, I am giving permission to Accupac to send me information about my insurance to this email address.

I understand I may change this authorization at any time by contacting the Benefits Department.

E-Mail *(please print clearly)* _____

HR Purpose Only:

Benefit effective date: _____

Section B – Dependent Information

LIST DEPENDENTS TO: ☐ ENROLL ☐ DELETE **Enter: E for Enroll / D for Delete**

	Name (Last/First/MI)	M/F	Date of Birth	SSN	Medical	Dental	Vision	Life
Spouse								
Dependent								
Dependent								
Dependent								
Dependent								
Dependent								

*Bi-Weekly Payroll Deductions (*Based on 26 pays per year)

Section C - Aetna Medical Options

	Single	EE + Child(ren)	EE+Spouse	Family	Waive
Aetna HDHP	☐ $61.96	☐ $138.20	☐ $171.94	☐ $232.44	☐
Aetna HMO*	☐ $94.39	☐ $198.06	☐ $238.91	☐ $327.40	☐
Aetna Choice POS	☐ $119.96	☐ $238.47	☐ $284.92	☐ $389.74	☐

***HMO Provider Name and ID#: _____**

To Search for a provider, please visit: www.Aetna.com and search plan name: "Aetna Select"
Spousal Exclusion applies to Medical Insurance

Section D - Aetna Dental

	Single	EE + Child(ren)	EE+Spouse	Family	Waive
Aetna PPO Dental	☐ $9.33	☐ $28.61	☐ $28.61	☐ $28.61	☐

Spousal Exclusions applies to Dental Insurance

Section E - EyeMed Vision

	Single	EE + Child(ren)	EE+Spouse	Family	Waive
EyeMed Vision	☐ $2.09	☐ $4.17	☐ $3.96	☐ $6.13	☐

Spousal Exclusions applies to Vision Insurance

Section F - Flex Spending Account / FSA

Employees eligible for benefits are also eligible to enroll in the Medical Flex Spending Account and Dependent Care FSA. You can put up to $3,050 in pretax dollars into the Medical FSA and up to $5,000 pretax dollars into the Dependent Care FSA.

Do you wish to enroll in an FSA? ☐ Yes ☐ No (**If yes, you must complete the FSA enrollment form.)**

If yes, please check type(s) of accounts: ☐ Medical ☐ Dependent Care

Section G - Health Savings Account / HSA

Employees enrolling in the Aetna HDHP are eligible to enroll in a Health Savings Account (HSA). You can put up to $3,850 for self only coverage and up to $7,750 for individual with family coverage in pretax dollars into an HSA. See the Benefits Newsletter for details.

Do you wish to enroll in a HSA? ☐ Yes ☐ No (**If yes, you must complete the HSA enrollment form.)**

Section H – Lincoln Supplemental Life Insurance

Employees are eligible to enroll for Supplemental Life Insurance with Lincoln Financial.

Do you wish to enroll for Supplemental Life Insurance? ☐ Yes ☐ No **(If yes, you must complete the Supplemental Life Insurance enrollment form and the Evidence of Insurability form.)**

➢*Payroll contributions for medical, dental and flexible spending accounts will automatically be withheld on a pretax basis. By signing below, I authorize the reduction of my salary on a per paycheck basis for coverage selected in this election form.*

➢*I understand that if my paycheck is not enough to cover my insurance premiums, I must make payment directly to Accupac within 30 days. If I do not pay the past due premiums within 30 days, I will be given 15 day's notice before my benefits will be terminated effective with the last day for which I have made payment.*

➢*I understand that I cannot change or revoke my election for medical, dental or flex spending account as of any date prior to the next open enrollment unless I experience a qualified change in status and complete the proper forms within 30 days of the change.*

Employee Signature: _____ Date: _____

HR Benefits Specialist: _____ Date: _____