2024 Benefit Election Form

Name_____ Date of Hire_____ Effective_____

Select your benefits below. **You** must enroll to insure dependents. Qualifying dependents can be covered up to age 26 or age 30 if a military veteran.

Benefit Plans	Options	Single	Single+1	Single+2	Enroll/ Waive	Per Pay Period Cost	
						Pre-Tax	Post-Tax
Medical	**Blue Cross Blue Shield**						
	PPO	$74.12	$167.48	$260.83		$	
	*HMO Illinois	$38.78	$80.76	$112.70		$	
	*Blue Advantage HMO	$36.07	$75.10	$104.81		$	
*Only available in Illinois							
Dental	**Blue Cross Blue Shield**						
	High	$4.45	$9.59	$17.21		$	
	Low	$2.11	$4.77	$9.60		$	
Vision	**EyeMed**						
	Vision	$2.60	$4.94	$7.26		$	
FSA	**WEX**	PPD Ded	#ppds to end of year	Total to end of year			
	Healthcare Flex Spending					$	
	Dependent Care Flex Spending					$	
Life/AD&D	**Blue Cross Blue Shield**						
	Life Insurance	2x salary			Enroll	$0 ALA Provided	
	AD&D	1.5x salary			Enroll	$0 ALA Provided	
Voluntary Life**	**Blue Cross Blue Shield**						
	Supplemental Life	_____	x salary				$
	Spouse/Domestic Partner Life	$25,000 of coverage $6.00	$50,000 of coverage $12.00	****			$
	Child(ren) Life	$10,000 of coverage $0.40					$
Voluntary Short Term Disability**	**Blue Cross Blue Shield**						$
Long Term Disability	**Blue Cross Blue Shield**				Enroll	$0 ALA Provided	

See Next Page for More Options

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Benefit Plans	Options	Enroll/ Waive	Per Pay Period Cost	
			Pre-Tax	Post-Tax

Plans Options Continued, Cost semi-monthly

	Single		Family		
Allstate Identity Protection**	$4.98		$8.98		$

	Single	EE+SP/ EE+CH	Family		
Guardian Critical Incidents**					
Hospital	$9.43	$17.02/ $15.05	$22.65		$
Accident	$6.51	$10.28/ $10.77	$14.54		$

Critical Illness	(See cost section for age rates)			
Options: Employee only -or Employee & Spouse/Domestic Partner	$20,000 Employee			$
-or Employee, Spouse/Domestic Partner, and Child(ren)	$10,000 Employee			$
	$10,000 Spouse/Domestic Partner			$
-or Employee and Child(ren) (Spouse/Domestic Partner can only have 50% of what employee has	$5,000 Spouse/Domestic Partner			$
	$5,000 Child			$0.00
Child(ren) can be up to 25% of Employee, to age 26)	$2,500 Child			$0.00

	$	$
Total per Pay period	$	

***deduction is semi-month otherwise by weekly*

*****evidence of insurability required*

_____I understand my election can only be changed during the open enrollment period which takes plan once each year. I want my contribution to be deducted from my check as indicated above as allowed under Section 125 of the Internal Revenue Code.

_____I Acknowledge that should I choose to retain this election in future year, my contribution may increase and I hereby authorize the increase in my payroll deductions.

Signature_____ Date_____