Employer Salary Reduction Agreement

Employee Election for Plan Year Beginning: 2021

Peninsula Agency on Aging
Linking Seniors & Services since 1974

EMPLOYEE INFORMATION

Name:	S.S.#:
Occupation / Job Title	Work Phone#:
Home Address:	Home/Cell Phone#:
City, State, & Zip:	Age:
Email:	Birth Date:

❑ No Change from Last Year ❑ This is a Change from Last Year

GROUP INSURANCE PLANS

Election #1: Group Medical Insurance

Check Plan	Group Insurance Plan Description			26 Pay Period Deductions	Monthly Billable Cost
	Option #1 Platinum Optima Health Vantage 20/20%				
	Employee Only Coverage			$128.97	$1,004.43
	Employee + Child Coverage			$314.40	$1,406.20
	Employee + Children Coverage			$592.55	$2,008.86
	Employee + Spouse Coverage			$638.91	$2,109.31
	Employee + Family Coverage			$1,009.78	$2,912.85
	Option #2 Gold Optima Health Vantage 1000/20/20%				
	Employee Only Coverage			$65.87	$867.72
	Employee + Child Coverage			$226.07	$1,214.81
	Employee + Children Coverage			$466.36	$1,735.44
	Employee + Spouse Coverage			$506.41	$1,822.22
	Employee + Family Coverage			$826.80	$2,516.39
	Option #3 Silver Optima Equity Vantage 2800/90%				
	Employee Only Coverage			$23.08	$647.32
	Employee + Child Coverage			$142.58	$906.25
	Employee + Children Coverage			$321.84	$1,294.65
	Employee + Spouse Coverage			$351.72	$1,359.38
	Employee + Family Coverage			$590.73	$1,877.24
	Optima EAP Program				
	Employee Only Coverage				

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Election #2: Group Dental Insurance

Check Plan	Group Insurance Plan Description			26 Pay Period Deductions	Monthly Billable Cost
	United Concordia				
	Employee Coverage			$15.96	$34.57
	Plus Spouse Coverage			$31.86	$69.03
	Plus Child(ren) Coverage			$28.76	$62.32
	Plus Family Coverage			$48.41	$104.88

❑ No Change from Last Year ❑ This is a Change from Last Year

Election #3: Group Term Life Insurance

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage		Deduction Amount
	SunLife			
	Employee Only	Employer Paid		$0.00

BENEFICIARY ELECTION

Name:_____ Relationship_____

Address_____ D.O.B._____

I understand that I do not choose a beneficiary, any life insurance benefits will be paid to my estate. I may choose to change beneficiaries at any time.

*** **Signature:** **Date:**

CONTINGENT BENEFICIARY ELECTION

Name:_____ Relationship_____

Address_____ D.O.B._____

I understand that I do not choose a beneficiary, any life insurance benefits will be paid to my estate. I may choose to change beneficiaries at any time.

*** **Signature:** **Date:**

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Election #4: Wellness Plan

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage
	Wellness Plan	
	Employee Only	
	Employee + Family	

Election #5: Cafeteria Plan Benefits

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	26 Pay Period Deductions	Monthly Billable Cost
	EyeMed			
	Vision Insurance			
		Employee Only	$3.10	$6.71
		Employee + Child(ren)	$6.19	$13.42
		Employee + Spouse	$5.88	$12.75
		Employee + Family	$9.11	$19.73
	Allstate (See Allstate brochure for insurance rates)			
	Disability Insurance			
		Employee Only		
	Accident Insurance			
		Employee Only		
		Employee + Family		
	Life Insurance			
		Employee		
		Spouse		
		Dependents		
	Critical Illness Insurance			
		Employee Only		
		Employee + Family		

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Election #4: Cafeteria Plan Benefits (cont.)

Check Plan	Group Insurance Plan Description	Type or Amount of Coverage	26 Pay Period Deductions	Monthly Billable Cost
	Hospital Income Insurance			
		Employee Only		
		Employee + Family		
	Legal Benefit			
		Employee + Family	$11.54	$25.00
	Identity Theft Protection			
	Option 1			
		Employee Only	$4.59	$9.95
		Employee + Family	$8.28	$17.95
	Option 2			
		Employee Only	$3.67	$7.95
		Employee + Family	$6.44	$13.95

PARTICIPATION ELECTION

I want to participate in the benefits package this plan year. I hereby make the following election regarding the benefits available to me under the Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, and this amount to be deducted in approximately equal sums from my regular paycheck during the current Plan Year.

I understand that I can not change this election during the plan year unless a change of status occurs such as a marriage, divorce, birth or termination, etc.

*** **Signature:** **Date:**

WAIVER OF ELECTION - ALL PLANS

I do not want to participate in any Plan Benefits at this time. I realize that I will not become eligible again until the beginning of the next Plan Year, or if earlier, a change of status occurs such as marriage, divorce, birth or termination.

*** **Signature:** **Date:**