2023-2024 Associate Enrollment Form

Effective Date:		Date of Hire:	

Purpose - Dates Required

- ❑ Open Enrollment
- ❑ New Hire
- ❑ Re-Hire Date:_____
- ❑ Part Time to Full Time
  Date FT: _____
- ❑ Qualifying Event
- ❑ Add Dependent
- ❑ Terminate Dependent
- ❑ Terminate - Other Coverage
- ❑ Reduction of Hours
- ❑ Name Change
- ❑ Address Change
- ❑ Salary Change
- ❑ Plan Change
- ❑ Going on Medicare

Effective Date of QE: _____

Reason: ❑marriage ❑divorce ❑birth ❑death ❑court order** ❑adoption** ❑loss/gain of coverage** **provide supporting documents

Employee Information

_____ _____ _____

Employee Name (Last, First, Middle) *DOB* *SSN*

_____ _____ _____ _____

Current Home Address (Street, Apt#) *City* *State* *Zip*

Phone # _____ ❑Male ❑Female ❑Single ❑Married

Email address _____

Hourly Rate: _____ Job Title:_____

Must complete application in FULL or it will be returned resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Dependent Information (covered dependents only)

Names of Covered Family Members	Gender		DOB	SSN
Spouse:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		

Medical (deductions are per pay period for your 1st, 2nd, 3rd, and 4th weeks of month)

BlueCross BlueShield of Texas

HDHP $6,650 Plan - Preventative covered 100% - see guide for details.

$15.00 - $19.99		$20.00 - $24.99		$25.00 - $29.99	
❑ Employee Only	$47.50	❑ Employee Only	$63.25	❑ Employee Only	$79.00
❑ Employee + Spouse	$271.90	❑ Employee + Spouse	$287.65	❑ Employee + Spouse	$303.40
❑ Employee + Child(ren)	$185.57	❑ Employee + Child(ren)	$201.32	❑ Employee + Child(ren)	$217.07
❑ Employee + Family	$409.97	❑ Employee + Family	$425.72	❑ Employee + Family	$441.47

$30.00- $34.99		$35.00 - $39.99		$40.00 - $44.99	
❑ Employee Only	$94.75	❑ Employee Only	$110.75	❑ Employee Only	$126.50
❑ Employee + Spouse	$319.15	❑ Employee + Spouse	$335.15	❑ Employee + Spouse	$350.90
❑ Employee + Child(ren)	$232.82	❑ Employee + Child(ren)	$248.82	❑ Employee + Child(ren)	$264.57
❑ Employee + Family	$457.22	❑ Employee + Family	$473.22	❑ Employee + Family	$488.97

$45.00 and $49.99		$50.00 and $54.99		$55.00 and Up	
❑ Employee Only	$142.25	❑ Employee Only	$158.00	❑ Employee Only	$172.61
❑ Employee + Spouse	$366.65	❑ Employee + Spouse	$382.40	❑ Employee + Spouse	$397.01
❑ Employee + Child(ren)	$280.32	❑ Employee + Child(ren)	$296.07	❑ Employee + Child(ren)	$310.68
❑ Employee + Family	$504.72	❑ Employee + Family	$520.47	❑ Employee + Family	$535.08

❑ **Waive Medical**

HSA Deductions (per weekly pay period)

HSA Plan Contribution

Please Note: It is your responsibility to ensure you are eligible to contribute and that you do not exceed the maximum contribution allowed

- ❑ Single $ _____ per pay period *(Annual IRS Contribution limit 2023-$3,850 | 2024-$4,150)*
- ❑ Family $ _____ per pay period *(Annual IRS Contribution limit 2023-$7,750 | 2024-$8,300)*
- ❑ Over 55 catch up $ _____ per pay period *(Annual IRS Contribution limit $1,000) - in addition to Single or Family Election*

❑ Waive

Dental (deductions are per pay period for your 1st, 2nd, 3rd, and 4th weeks of month)

BlueCross BlueShield of Texas

Dental Plan - Low Plan 45		Dental Plan - High Plan 54	
❑ Employee Only	$3.35	❑ Employee Only	$6.77
❑ Employee + Spouse	$6.68	❑ Employee + Spouse	$13.53
❑ Employee + Child(ren)	$9.97	❑ Employee + Child(ren)	$18.20
❑ Employee + Family	$14.84	❑ Employee + Family	$27.59

❑ Waive

Vision (deductions are per pay period for your 1st, 2nd, 3rd, and 4th weeks of month)

EyeMed Vision

Vision Plan

❑ Employee Only	$2.06
❑ Employee + Spouse	$3.92
❑ Employee + Child(ren)	$4.12
❑ Employee + Family	$6.06

❑ Waive

I verify that the information provided in this enrollment form is accurate and complete. I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan (Section 125), and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or if I experience a significant change in family status (called a "Life Event") such as, gaining or losing dependents through Birth, Death, Marriage, Divorce, or gaining or losing other health coverage, etc. I understand that I must make any changes within 30 days of the approved "Life Event." I understand that by not applying for the coverages contained herein, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for approval. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed. Additionally, I agree, for myself and for any eligible dependent listed, to abide by the rules and regulations of the plan, terms and conditions of all the Service Agreements for the Plans I have elected.

Employee Signature _____ *Date* _____