2022 Health Benefits Election & Payroll Deduction Authorization Form

The Inventive-Group and IWS Sales offers medical insurance through SelectHealth and pays 50% of the monthly premium for employee and children. Employees pay the remaining 50% and 100% for spouses. Voluntary dental and vision plans are also available. **Employees are responsible for 100% of the voluntary benefits**. The Summary of Benefits and Coverage are available for each plan. Deductions are taken from the first two paychecks of each month which is 24 deductions per year. The employee share is deducted one month prior to the effective date.

1. Employee Information: SSN: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: _____ Date of Birth: _____ Phone: _____ Hire Date: _____

Marital Status: _____ (D=Divorced, M=Married, I=Single,) **Email**: _____

2. Medical Benefit Plan:

Plan Choice (Initial One)	SelectHealth - Medical	Monthly Premium	Employee Share	24 Deductions per year
	Employee Only	**$ 376.20**	**$ 188.10**	**$ 94.05**
	Employee + Spouse*	**$ 790.00**	**$ 601.90**	**$ 300.95**
	Employee + Child*	**$ 523.20**	**$ 261.60**	**$ 130.80**
	Employee + Children*	**$ 741.60**	**$ 370.80**	**$ 185.40**
	Family*	**$ 1,166.20**	**$ 795.40**	**$ 397.70**

3. Voluntary Benefit Plans: The following choices are offered at full cost to the employee.

Initial Your Choices	Plan	Coverage Type	Monthly Premium	24 Deductions per year
	Dental – Blue Cross	**Employee Only**	**$ 27.20**	**$ 13.60**
	Dental – Blue Cross	**Employee + Spouse***	**$ 55.56**	**$ 27.78**
	Dental – Blue Cross	**Employee + Child***	**$ 48.80**	**$ 24.40**
	Dental – Blue Cross	**Employee + Children***	**$ 87.50**	**$ 43.75**
	Dental – Blue Cross	**Family**	**$101.46**	**$ 50.73**
	Vision - Avesis Essential	**Employee Only**	**$ 6.66**	**$ 3.33**
	Vision - Avesis Essential	**Employee + Spouse***	**$ 12.62**	**$ 6.31**
	Vision - Avesis Essential	**Employee + Child/Children***	**$ 13.76**	**$ 6.88**
	Vision - Avesis Essential	**Family***	**$ 17.68**	**$ 8.84**

4. Waiver of Coverage.

	I have been given the opportunity to enroll and I choose **NOT** to participate in the company's medical plan. I understand I will not be eligible to enroll again until the next open enrollment period or during situations permitting special enrollment. Waive Reason: ☐ I already have health insurance through _____. ☐ I do not want to buy health insurance at this time.
	I have been given the opportunity to enroll and I choose **NOT** to participate in the company's medical plan. However, I WANT to enroll in the voluntary Dental and/or Vision plans. I understand I will not be eligible to enroll into again the medical plan until the next open enrollment period or during situations permitting special enrollment. Waive Reason: ☐ I already have health insurance through _____. ☐ I do not want to buy health insurance at this time.

5. I authorize In The Ditch/IWS Sales to make deductions from my earnings towards the cost of coverage or waive coverage.

Signature	*Date*

6. Dependent Information. Complete this section if you selected plan(s) which cover eligible dependent(s). List all eligible dependents (spouse 1st and then children) whom you wish to cover. List children in order of age (oldest to the youngest). List the relationship of all children to the employee in the "Relationship" column. If you need more space, use another form.

NUMBER OF DEPENDENTS YOU ARE ENROLLING________.

Dependent Information: Dependent SSN: ________________________

Relationship Code: ____ (S=Spouse, C=Child, G=Legal Guardian, L=Adopted Child)

First Name: ________________________ Middle Initial: _____ Last Name: ________________________

☐ Check box if same as employee's address

Address: ________________________ City: ________________________ State: ____ Zip: _____________

Gender: _____ Date of Birth: _____________ Phone: __________________

Dependent Information: Dependent SSN: ________________________

Relationship Code: ____ (C=Child, G=Legal Guardian, L=Adopted Child)

First Name: ________________________ Middle Initial: _____ Last Name: ________________________

☐ Check box if same as employee's address

Address: ________________________ City: ________________________ State: ____ Zip: _____________

Gender: _____ Date of Birth: _____________ Phone: __________________

Dependent Information: Dependent SSN: ________________________

Relationship Code: ____ (C=Child, G=Legal Guardian, L=Adopted Child)

First Name: ________________________ Middle Initial: _____ Last Name: ________________________

☐ Check box if same as employee's address

Address: ________________________ City: ________________________ State: ____ Zip: _____________

Gender: _____ Date of Birth: _____________ Phone: __________________

Dependent Information: Dependent SSN: ________________________

Relationship Code: ____ (C=Child, G=Legal Guardian, L=Adopted Child)

First Name: ________________________ Middle Initial: _____ Last Name: ________________________

☐ Check box if same as employee's address

Address: ________________________ City: ________________________ State: ____ Zip: _____________

Gender: _____ Date of Birth: _____________ Phone: __________________

Dependent Information: Dependent SSN: ________________________

Relationship Code: ____ (C=Child, G=Legal Guardian, L=Adopted Child)

First Name: ________________________ Middle Initial: _____ Last Name: ________________________

☐ Check box if same as employee's address

Address: ________________________ City: ________________________ State: ____ Zip: _____________

Gender: _____ Date of Birth: _____________ Phone: __________________