Collins-Maxwell CSD

2013-2014 Plan Year

Employee Benefits Package & Enrollment Form

Employee Information	
☐New Hire ☐Late Enrollee ☐Special Enrollee ☐Change **Hire Date:**	
Name:	**Social Security Number:**
Address:	
Telephone:	☐**Male** ☐**Female**
Date of Birth:	**Marital Status:** ☐Single ☐Married ☐Common Law
Email:	**Employment Status:** ☐Active ☐Retiree

Dependent Information			
Name	DOB	SSN	Coverage
			☐Medical ☐Dental ☐Vision ☐Flex
			☐Medical ☐Dental ☐Vision ☐Flex
			☐Medical ☐Dental ☐Vision ☐Flex
			☐Medical ☐Dental ☐Vision ☐Flex
			☐Medical ☐Dental ☐Vision ☐Flex
			☐Medical ☐Dental ☐Vision ☐Flex
			☐Medical ☐Dental ☐Vision ☐Flex

Medical Plan Wellmark/Advantage Administrators	**Plan Option 1**	**Plan Option 2**
Annual Deductible		
Single	$500	$1000
Family	$1000	$2000
Coinsurance	30%	30%
Out-of-Pocket Maximum		
Single	$1000	$2000
Family	$2000	$4000
Copays		
Primary Care	$25	$25
Specialist	$50	$50
Emergency Room	$250	$250
Prescription Copays		
Single Deductible	$100 (waived for generic)	$100 (waived for generic)
Family Deductible	$200 (waived for generic)	$200 (waived for generic)
Generic Tier 1	$8	$8
Tier 2	$35	$35
Tier 3	$50	$50
Tier 4	$85	$85
Self-Administered Specialty Drugs	$85	$85
Employee Costs (Monthly)		
Single	$1 at enrollment	$1 at enrollment
Family	$632.65	$542.65
Enrollment (mark appropriate box)		
Single	☐	☐
Family	☐	☐
Waive/Terminate	☐	
Dual Coverage ☐Yes (Provide other carrier information at enrollment)		

Dental Plan Delta Dental of Iowa	**Deductible**	**Coinsurance**	**Benefit Period Maximum**
Benefit Categories	$25 Single $50 Family		$1000
Check-Ups & Cleanings (Diagnostic & preventive)	Waived	0%	Yes
Cavity Repair & Tooth Extractions	Yes	20%	Yes
Root Canals	Yes	20%	Yes
Gum & Bone Diseases	Yes	20%	Yes
High Cost Restoration	Yes	50%	Yes
Dentures & Bridges	Yes	50%	Yes

Employee Costs (Monthly)	
Single	$15.24
Family	$75.08

Enrollment

Single☐ Family☐ Waive/Terminate☐ Dual Coverage☐ (Provide other carrier information at enrollment)

Vision Discount Plan Avesis	**Benefits**
Vision Exam	Save 20% off the provider retail fees
Frames	Save 20% off the provider retail fees
Spectacle Lenses	Save 20% off the provider retail fees
Contact Lenses	Save 20% off the provider retail fees
Lens Options	Save 20% off the provider retail fees
Specialty Lenses	Save 20% off the provider retail fees

Employee Costs (Annual)	
Employee + Family (only one rate)	$25.50

Enrollment

Elect ☐ Waive/Terminate ☐

Life & AD&D Insurance

Guarantee Life Insurance Co.

1 x Basic Annual Earnings, rounded to the next higher $1000

Long Term Disability

Guarantee Life Insurance Co.

Elimination Period	14 days or the number of accumulated sick leave days (whichever is greater) of Disability due to the same or a related Sickness or Injury, which must be accumulated within a 28 day period, or twice the number of accumulated sick leave days (whichever is greater).
Benefit	60% of earnings up to $5000 a month
Benefit Period	(For sickness or injury): The insured person's social security normal retirement age, or the maximum benefit period show below (whichever is later).

Age at Disability	Maximum Benefit Period
Less than Age 60	To Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

There is no cost to the employee for the life and disability benefits as long as they meet eligibility.

Flexible Benefits Plan Advantage Administrators
Healthcare Spending Account (Maximum Benefit allowed $2500) ☐ Yes I elect to contribute $_______________ annually (before taxes) for the PLAN YEAR, which is $______________per pay period to fund my account that pays qualified out-of-pocket health care expenses not covered by my health or other insurance plans. ☐ No I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.
Dependent Care Benefit Account (Maximum Benefit allowed $5000 for joint filers and $2500 for single filers) ☐ Yes I elect to contribute $________________ annually (before taxes) for the PLAN YEAR, which is $_____________per pay period to fund my account that pays qualified dependent care expenses. ☐ No I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.
Optional Reimbursement Services: Reimbursements are sent by check unless otherwise noted below. Email (required for direct deposit and debit card users):____ ☐ Yes I want the convenience of direct deposit for my plan reimbursement. I hereby authorize Advantage Administrators to initiate deposits into my ☐ checking account or ☐ savings account as indicated below. Please be sure to write your numbers clearly on the form or attach a voided check. Notification of deposits will be sent by email. Routing Number:_______________________________ Bank Account Number:_________________________________
☐ Yes I want the convenience of using the flex debit card to pay qualified expenses. I understand that the annual card fee is $15 and will be paid for by Collins-Maxwell CSD and includes one extra card for my spouse or a dependent. Name of Second Card Holder: ____ **Debit Card Agreement:** I understand that the flex benefits card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by another plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the flex benefits card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if payment is made that it is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck.

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Signature Date