2025 Benefits Enrollment

EMPLOYEE ID#: _____

DATE OF HIRE: _____

Check the box that applies:

☐ Change Health only ☐ Change Dental only
☐ Change Health and Dental ☐ Add Vision only
☐ Drop Coverage ☐ Dependent Change
☐ Premium Change Only ☐ FSA ☐ HSA

Employee Information				
Last Name	First name	Middle Initial	SSN	
Mailing Address – Please specify if this is a new address ☐		City	State	Zip Code
Business or Cell Phone	Home Phone	Email Address – required for FSA debit card		
Date of Birth	Gender	**Marital Status** ☐ Single ☐Married ☐ Widowed ☐Divorced	Job Title/Department	
Preference for Communications ☐ Standard Mail ☐Home Phone ☐ Work / Cell Phone ☐ Work Email ☐ Home Email				
Enrollment / Change Reason ☐ Open Enrollment ☐ New Hire ☐ Rehire ☐ Termination ☐ Return from Active Duty ☐ Qualifying Event		**If Qualifying Event, Choose one:** ☐ Marriage ☐ Divorce ☐ Adoption ☐ Birth ☐ Death ☐ Loss of Coverage ☐ Spouse Employment Change		

Dependent Information – Complete Only for New or Terminating Dependents

Your eligible dependents include (a) your legal spouse; (b)Your children who are under age 26; (c) your legally adopted children; (d) your step children.

Relationship	First Name	Last Name	MI	Gender	Date of Birth	Social Security #	Change Reason
							☐ Add ☐ Term
Relationship	First Name	Last Name	MI	Gender	Date of Birth	Social Security #	Change Reason
							☐ Add ☐ Term
Relationship	First Name	Last Name	MI	Gender	Date of Birth	Social Security #	Change Reason
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							☐ Add ☐ Term
Relationship	First Name	Last Name	MI	Gender	Date of Birth	Social Security #	Change Reason
							☐ Add ☐ Term

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Plan A (High Deductible Health Plan) Select Single + One Other Category if Insuring Dependents				
	DEDUCTION CODE	**BI-WEEKLY PREMIUM**	**CURRENT BI-WEEKLY**	**REVISED BI-WEEKLY AMOUNT**
Single	(SGPLA)	☐ $50.78		
Spouse	(FMPLA1)	☐ $60.18		
Child(ren)	(FMPLA2)	☐ $33.64		
Family	(FMPLA)	☐ $88.62		
Plan A Optional Election – HSA – 2025 Contribution Limit - $4,300 individual/$8,550 Family				
☐ **HSA (Waive FSA)**	☐Waive	☐ **Continue current amount**	**New Annual $_____**	
Plan B Coupe – Select Single + One Other Category if Insuring Dependents Note: If you are electing this plan you are required to complete the MFOF form				
	DEDUCTION CODE	**BI-WEEKLY PREMIUM**	**CURRENT BI-WEEKLY**	**REVISED BI-WEEKLY AMOUNT**
Single	(SGPLB)	☐ $60.94		
Spouse	(FMPLB1)	☐ $73.38		
Child(ren)	(FMPLB2)	☐ $41.26		
Family	(FMPLB)	☐ $109.44		
Plan B Coupe Optional Election – FSA – 2025 Contribution Limit - $3,300				
☐ **Medical FSA** (Waive HSA)	☐Waive		**New Annual $_____**	
Dental				
☐**Dental**	☐Waive	☐$5.35 Single Only	☐$15.68 Family Only	
Vision				
☐**Vision**	☐Waive	☐$2.56 Single Only	☐$6.52 Family Only	☐ **Included in both health plans**
Dependent Care – Contribution Limit - $5,000 married/ $2500 married filing separately				
☐ **Dependent Care FSA**	☐Waive		**New Annual $_____**	

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above.

Employee Signature_____Date_____

HR USE ONLY			
Employee ID_____ **Employee Group** ☐ City Employee ☐ EPTA ☐ Police ☐ Fire ☐ Retiree	**Effective Date** **January 1, 2025**	**Date and reason family status change occurred:** **2025 Open Enrollment**	**First pay date reflecting change:** **January 03, 2025**