Employee Benefits Election Form

For Coverage Period 7/1/25-12/31/25

**Section 1: Employee Information**

|  |
| --- |
| Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] My personal information has not changed |
| [ ] I need to make changes to my information:Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City, State, ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 2: Medical Plan Selection**

Please choose one medical plan option:

[ ] Complete Care

[ ] Essential Care

[ ] Care Plus w/ HSA

☐ I do not wish to elect medical coverage at this time

Enroll As: [ ] Employee Only [ ] Employee + Spouse [ ] Employee + Child(ren) [ ] Employee + Family

**Section 3: Dental Coverage**

Would you like to elect Dental Coverage?

[ ] Yes – Elect dental

[ ] No – Waive dental

Enroll As: [ ] Employee Only [ ] Employee + Spouse [ ] Employee + Child(ren) [ ] Employee + Family

**Section 4: Vision Coverage**

Would you like to elect Vision Coverage? – Only required if not enrolled in Medical

[ ] Yes – Elect vision

[ ] No – Waive vision

Enroll As: [ ] Employee Only [ ] Employee + Spouse [ ] Employee + Child(ren) [ ] Employee + Family

**Section 4: FSA or LPFSA Election *(Maximum $126.00)***

Would you like to elect a FSA or LPFSA deduction

[ ] Yes – Elect $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per pay period

[ ] No – Waive FSA/LPFSA

**Section 4: DCA Election *(Maximum $192.00)***

Would you like to elect a DCA Election

[ ] Yes – Elect $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per pay period

[ ] No – Waive DCA

**Section 4: HSA Election – Only if enrolled in Core HSA Plan**

***(Maximum $150 per pay for Employee Only, $300 per pay for Employee + Dependents)***

Would you like to have HSA funds deducted from your paycheck

[ ] Yes – Elect $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per pay period

[ ] No – Waive HSA – you will not receive the NKHS match

**Section 5: Dependent Enrollment / Changes**

Are you making changes to dependent enrollment?

[ ] Yes
[ ] No

If yes, indicate below for: [ ] Medical [ ] Dental [ ] Vision

|  |  |  |  |
| --- | --- | --- | --- |
| Dependent Name | DOB | Relationship | Add/Remove |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Add [ ] Remove |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Add [ ] Remove |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Add [ ] Remove |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Add [ ] Remove |

I have a domestic partner:

[ ] Yes
[ ] No

If you have a new domestic partner, please complete the Domestic Partner Affidavit provided by HR (Your domestic partner is considered a “Spouse” when reviewing benefits)

**Section 6: Authorization**

By signing below, I authorize the above elections and understand that changes can only be made during open enrollment or with a qualifying life event.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_