



# WARREN COUNTY

## 2016-17 UNIVERSAL ENROLLMENT FORM

### ▶ TELL US ABOUT YOURSELF:

NAME (FIRST NAME + MI + LAST NAME)	SOCIAL SECURITY #	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MM/DD/YY)	
MAILING ADDRESS (STREET, APT No.)	CITY	STATE	ZIP CODE	TELEPHONE

### ▶ INFORMATION ABOUT FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN:

NAME (FIRST NAME + MI + LAST NAME)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER
SPOUSE			<input type="checkbox"/> M <input type="checkbox"/> F
DEPENDENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			<input type="checkbox"/> M <input type="checkbox"/> F
DEPENDENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			<input type="checkbox"/> M <input type="checkbox"/> F
DEPENDENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			<input type="checkbox"/> M <input type="checkbox"/> F

### ▶ WHICH PLAN TYPE(S) & COVERAGE AMOUNT(S) ARE YOU ENROLLING IN?

#### BSNENY EPO 5010

Estimated Semi-Monthly Payroll Deductions	13%	15%	20%	22%
Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual	\$43.35 <input type="checkbox"/>	\$50.02 <input type="checkbox"/>	\$66.69 <input type="checkbox"/>	\$73.36 <input type="checkbox"/>
Co- Individual	\$36.10 <input type="checkbox"/>	\$42.94 <input type="checkbox"/>	\$60.03 <input type="checkbox"/>	\$66.86 <input type="checkbox"/>
2 - Person	\$88.87 <input type="checkbox"/>	\$102.54 <input type="checkbox"/>	\$136.72 <input type="checkbox"/>	\$150.39 <input type="checkbox"/>
Family	\$124.62 <input type="checkbox"/>	\$143.79 <input type="checkbox"/>	\$191.72 <input type="checkbox"/>	\$210.89 <input type="checkbox"/>

EPO Plan Changes   Add Dependent (list above)    Remove Dependent (list above)    Deduct from my pay POST-TAX

#### BSNENY HDEPO 6310

Estimated Semi-Monthly Payroll Deductions	13%	15%	20%	22%
Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual	\$33.42 <input type="checkbox"/>	\$38.56 <input type="checkbox"/>	\$51.41 <input type="checkbox"/>	\$56.55 <input type="checkbox"/>
Co- Individual	\$27.83 <input type="checkbox"/>	\$33.10 <input type="checkbox"/>	\$46.27 <input type="checkbox"/>	\$51.54 <input type="checkbox"/>
2 - Person	\$68.50 <input type="checkbox"/>	\$79.04 <input type="checkbox"/>	\$105.39 <input type="checkbox"/>	\$115.93 <input type="checkbox"/>
Family	\$96.06 <input type="checkbox"/>	\$ 110.84 <input type="checkbox"/>	\$147.78 <input type="checkbox"/>	\$162.56 <input type="checkbox"/>

HDEPO Plan Changes   Add Dependent (list above)    Remove Dependent (list above)    Deduct from my pay POST-TAX

*Delta Dental	Estimated Semi-Monthly Payroll Deductions
Waive	<input type="checkbox"/>
Individual	\$9.88 <input type="checkbox"/>
Family	\$26.28 <input type="checkbox"/>

Dental Plan Changes:   Add Dependent (list above)    Remove Dependent (list above)    Deduct from my pay POST-TAX

\* Pre-Medicare Retirees and Post-Medicare are Non-Eligible for Dental \*

### ▶ EMPLOYEE CERTIFICATION:

*I have reviewed my benefit elections and they are correct. I understand that any changes during the year need approval from the Human Resources Department. I understand that by waiving benefits I will not be allowed to change this election outside of Open Enrollment, except for qualifying events (i.e. loss of other coverage; marriage; divorce; newborn child; adoption) within 31 days of the event. All payroll deductions related to these elections, will be made on a pre-tax basis. I realize that there may be a small reduction in my future Social Security benefits due to this reduced amount of taxable income, and that I cannot revoke or change these pre-tax deduction elections during the plan year unless there is a qualifying event as permitted by state and federal tax law. Please check the POST-TAX box above for each plan where you would like the deductions made on a post-tax basis instead of the pre-tax basis. For any benefit, which I have specifically requested to have deducted from my pay on a post-tax basis, I realize that I will be paying state and federal, Medicare and Social Security taxes on those deductions. I authorize my employer to deduct the corresponding payroll deductions from my paycheck.*

**EMPLOYEE SIGNATURE** \_\_\_\_\_ **DATE SIGNED:** \_\_\_\_\_

### TO BE COMPLETED BY EMPLOYER:

**HIRE DATE:** \_\_\_\_\_ **EFFECTIVE:** \_\_\_\_\_ **EMPLOYER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**(NEW HIRES)**