

# WARREN COUNTY 2016-17 UNIVERSAL ENROLLMENT FORM

**▶ TELL US ABOUT YOURSELF:**

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

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

NAME (FIRST NAME + MI + LAST NAME)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER
<b>SPOUSE</b>			<input type="checkbox"/> M <input type="checkbox"/> F
<b>DEPENDENT</b> <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			<input type="checkbox"/> M <input type="checkbox"/> F
<b>DEPENDENT</b> <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			<input type="checkbox"/> M <input type="checkbox"/> F
<b>DEPENDENT</b> <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 Bi-Weekly Payroll Deductions	13%	20%
<b>Waive</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Individual</b>	\$43.35 <input type="checkbox"/>	\$66.69 <input type="checkbox"/>
<b>Co- Individual</b>	\$36.10 <input type="checkbox"/>	\$60.02 <input type="checkbox"/>
<b>2 - Person</b>	\$88.87 <input type="checkbox"/>	\$136.72 <input type="checkbox"/>
<b>Family</b>	\$124.61 <input type="checkbox"/>	\$191.71 <input type="checkbox"/>

**Plan Changes**    Add Dependent (list above)     Remove Dependent (list above)

**BSNENY HDEPO 6310**

Estimated Bi-Weekly Payroll Deductions	13%	20%
<b>Waive</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Individual</b>	\$33.42 <input type="checkbox"/>	\$51.41 <input type="checkbox"/>
<b>Co- Individual</b>	\$27.83 <input type="checkbox"/>	\$46.27 <input type="checkbox"/>
<b>2 - Person</b>	\$68.50 <input type="checkbox"/>	\$105.39 <input type="checkbox"/>
<b>Family</b>	\$96.06 <input type="checkbox"/>	\$147.78 <input type="checkbox"/>

**Plan Changes**    Add Dependent (list above)     Remove Dependent (list above)

**\*Delta Dental**

Estimated Bi-Weekly Payroll Deductions	
<b>Waive</b>	<input type="checkbox"/>
<b>Individual</b>	\$9.88 <input type="checkbox"/>
<b>Family</b>	\$26.28 <input type="checkbox"/>

**Plan Changes**    Add Dependent (list above)     Remove Dependent (list above)

**▶ 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 contact the Human Resources Department if you are interested in having these 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)