HOOD COUNTY BENEFIT ELECTION FORM

Plan Year from October 1, 2022 through September 30, 2023

EMPLOYEE NAME: ____ SS#: __________ (Last 4 digits)

I understand that my employer is allowing the following amounts for the purchase of benefits under the Section 125 Flexible Benefit Plan. I further understand than I cannot exceed the maximum elective salary reduction contribution per month effective October 1, 2022, through September 30, 2023. Amounts not used for benefits will be taxable income. Should the cost for benefits elected exceed amounts allowed under the plan, the excess amounts will be payroll deducted from after-tax dollars.

ALL DEDUCTIONS ARE FOR 24 PAY PERIODS

BENEFIT	Deduction Code		PREMIUM Per Pay Period (Pre-tax in Cafeteria)	PREMIUM Per Pay Period (Out of Cafeteria)
MEDICAL - EMPLOYEE – TAC EO_______ Waived _____	90		Employer Paid	
MEDICAL - DEPENDANT – TAC E & Spouse_____ E & Child____ Family____	50			
VISION – EYEMED – TAC EO______ Waived_____	94		Employer Paid	
VISION – DEPENDANT – TAC E & Spouse_____ E & Child_____ Family_____	56			
DEARBORN NATL GROUP TERM LIFE	91		Employer Paid	
DEARBORN VOLUNTARY GRP TERM LIFE	16			
DENTAL – AMERITAS LOW____HIGH___ EO_____E & Spouse____ E & Ch____Family____	54-High 62-Low			
SHORT TERM DISABILITY (AUL)	22			
MEDICAL SAVINGS ACCOUNT (FSA)	66			
ACCIDENT POLICY- MANHATTAN	63			
ACCIDENT POLICY- DISABILITY RIDER	26			
CANCER - TRANSAMERICA	64			
TOTAL PER PAY PERIOD				
			PRE-TAX	**POST-TAX**

TOTAL PRE-TAX + AFTER TAX:__________

[ ] I agree this election cannot be revoked or changed during the plan year, unless there is a change in my family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and employment or termination of employment of spouse with regard to loss or gain of insurance benefits) which justifies the revocation or change as authorized by the Internal Revenue Code and Regulations. I understand that any difference between employer paid amounts indicated above for any benefit and the actual cost of the benefit will be the property of the employer. I understand that if I fail to execute a new Benefit Form for any subsequent plan year, the then current Benefit Form will remain in effect unless cancelled by me in writing.

[ ] I decline participation in this Cafeteria Plan. I understand that I will not be eligible to participate again until the following year.

ALL COVERAGES FOR EMPLOYEES ELIGIBLE FOR OPEN ENROLLMENT BECOME EFFECTIVE OCTOBER 1, 2022. COVERAGES FOR EMPLOYEES HIRED AFTER OCTOBER 1, 2022, BECOME EFFECTIVE ON THE 1ST OF THE MONTH FOLLOWING 60 DAYS AFTER HIRE DATE. EFFECTIVE DATE IS ________________ (mm/dd/year).

Signature of Employee:____ Date: _________________