Name

Location

July 1, 2025-June 30, 2026 Plan Election and Premium Confirmation Form

The Local Choice MEDICAL INSURANCE (DENTAL & VISION INCLUDED)

☐ I accept coverage and authorize payroll deductions. ***Please make selection below*** .

☐ I decline Medical coverage. ***Please check reason for declining coverage*** .

☐ On Spouse's Plan ☐ Medicare / Medicaid ☐ Don't want coverage

☐ On Individual Plan ☐ Healthcare.gov / Marketplace ☐ Military

☐ New Hire

Payroll Deductions (*per payroll*)		The Local Choice HDHP $3300/20%/5000		The Local Choice Key Advantage $1000/20%/5000	Monthly Cost HSA Plan	Monthly Cost $1K Plan
Employee Only		$0.00		$84.55	$0.00	$169.10
Employee + Spouse		$268.74		$408.55	$537.47	$817.10
Emp + Spouse (2 EE's)		$0.00		$106.20	$0.00	$212.40
Employee + Child		$101.40		$323.21	$202.80	$646.42
Employee + Children		$101.40		$323.21	$202.80	$646.42
Employee + Family		$469.38		$732.01	$938.75	$1,464.02
Emp. + Family (2 EE's)		$0.00		$571.06	$0.00	$1,142.12

HealthEquity Health Savings Account (HSA) *Must make an election even if currently enrolled

☐ Employer AND Employee funded - please create an account for me. I understand I must complete carrier enrollment.

☐ I decline this account.

HealthEquity FLEXIBLE SPENDING ACCOUNT (FSA) *Must make an election even if currently enrolled

☐ Employee paid - please ENROLL me in this account. I understand I must complete the carrier enrollment.

☐ I decline Voluntary Employee Paid FSA benefits.

TRANSAMERICA VOLUNTARY ACCIDENT INSURANCE

☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment. ***Please see HR for rates and forms.***

☐ I decline Voluntary Employee Paid Benefits.

☐ Currently Enrolled - No Change

TRANSAMERICA VOLUNTARY CRITICAL ILLNESS INSURANCE

☐ Employee paid - please ENROLL me in this coverage. I understand I must complete the carrier enrollment AND Evidence of Insurability forms, and must be approved through their underwriting process before the benefit will begin. ***Please see HR for rates and forms.***

☐ I decline Voluntary Employee Paid Benefits.

☐ Currently Enrolled - No Change

I have been offered the above employee benefit options and I have selected my choices. I agree to allow my employer to deduct the appropriate premium(s) from my wages. I also understand I may not change coverage or family status unless I have a qualifying event or until the next open enrollment.

Signature

Date