BIBB COUNTY SCHOOL DISTRICT

STRENGTH OF CHARACTER AND COLLEGE READY

Benefit Election Form 2024

Semi-Monthly Premiums

& 125 Cafeteria Plan Premium Deduction Authorization

Employee Name	Gender	◯ Married ◯ Single	Birth Date	Hire Date
Address	Location	Last 4 of Social Security Number		Employee ID
City State Zip	Location/Occupation			Annual Earnings
Paymode ____Semi Monthly ____Monthly	Home Phone	Email Address		Effective Date
New Employee or Change	Change Due To: Marriage	Other :	Actively at work? ◯ Yes ◯ No	☐ COBRA ☐ Retiree

I ELECT TO RECEIVE THE FOLLOWING COVERAGES: My employer & I agree that my cash compensation will be reduced by the amounts below for enrolled benefits from each pay period during the plan year (or such portion of the plan year that remains after the date of this agreement). Premiums for eligible benefits will be deducted on a pre-tax basis; *or* I choose to opt out of the Cafeteria Plan and elect that all insured premiums be deducted on an after-tax basis.

		Monthly Deduction
State Health Benefit Plan	**Must enroll within 31 days of employment or qualifying "life" event.**	
Dental – MetLife	☐ Employee Only $15.00 ☐ Family $43.72	$ _____ ____Decline
Vision – BCBS BlueVision *$10/Exam $15/Materials*	☐ Employee Only $2.78 ☐ Employee + One $4.75 ☐ Family $8.10	$ _____ ____Decline

Covered Dependents

Dental	Vision	First, Middle Initial, Last Name	Relationship	Birth Date	SSN (Required)	Student/ Handicap
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Basic Group Life Insurance- Voya Amount reduces to 50% at age 70 — Initial if Declining Coverage	Benefit: 1X Salary Up to $50,000 Max	Provided by Bibb County at No Cost
Employee Supplemental Group Life Insurance- Voya *Rates are per $1000 of Benefit- 3X Salary is Guarantee Issue to $500,000* *Choose One:* 0X Select your Age: To Age 29 .035 Amount reduces to 50% at age 70	Salary/$1000 _____ Times Rate for Age _____ Times Multiple of Salary _____ Monthly Premium	$ _____ ____Decline
Dependent Group Life Insurance – Voya Covers Spouse & all unmarried dependent children from 6 months old up to age 26 if unmarried. $500 for children 14 days to 6 months.	Benefit $5,000 Rate $0.89//mo.	$ _____ ____Decline
Medical Flexible Spending Accounts – MedCom Pre-Tax Account set aside for medical, dental, vision, etc. that are not covered under other insurance plans. MasterCard will be issued for Employee Convenience.	Maximum semi-monthly is $127.03 $3,050Annual	$ _____ ____Decline
Dependent Care Flexible Spending Accounts – MedCom Pre-Tax Account set aside for dependent children daycare expenses. Same Use It or Lose It IRS Rule and Master Card Issuance as Medical Flexible Spending.	Maximum semi-monthly is 208.33 $5,000 Annual	$ _____ ____Decline

FORM MUST BE SIGNED AND SUBMITTED TO BIBB COUNTY SCHOOLS BENEFITS DEPARTMENT 01/02/2024

Long Term Disability- Cigna
Choose between 2 Plans, Elimination Period & Monthly Amount- $200 to $7500 not to exceed 66.67% salary. Plan includes a 3/12 pre-existing limitation.
See Rate Chart for rates for Plan 1 and Plan 2 Select Election Choice Below:

Plan # 1-- Benefits are payable to age 65

Elimination	☐ 14 days	☐ 30 days	☐ 60 days	☐ 90 days	☐ 180 days

Plan # 2-- Benefits are for 5 years

Elimination	☐ 14 days	☐ 30 days	☐ 60 days	☐ 90 days	☐ 180 days

Plan # _____

Monthly Amount_____

$ _____

____ Decline

Cancer Guardian- WGA
Program that helps identify risk of cancer and provides support if diagnosed

Employee* $9.00 all ages Employee/Spouse* $18.00 All Ages

*Children included at no cost

$ _____

____Decline

Compass Critical Illness- Voya
Choose to cover Employee and Spouse and/or Children & Choose the Benefit Level: Rates are based on age/tobacco

See Rate Chart and plan information for details

Employee ☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ *Tobacco*
Spouse ☐ $5,000 ☐ $10,000 ☐ *Tobacco*
Child/ren ☐ $5,000 ☐ $10,000

$_____

____Decline

Compass Hospital – Voya
Choose to cover Employee and Spouse and/or Children & Choose the Benefit Level

See brochure for plan information for details

	$100 daily	$200 daily	$300 daily
Employee	☐ $6.38	☐ $12.57	☐ $18.86
& Spouse	☐ $12.23	☐ $24.45	☐ $36.67
& Children	☐ $9.16	☐ $18.31	☐ $27.46
Family	☐ $15.10	☐ $30.18	☐ $57.78

$ _____

____Decline

Cancer & Accident Insurance
AFLAC Cancer and/or Accident Application must be completed and approved before coverage is in force.

If you are interested in enrolling in Aflac Cancer please see Katrina Swindle in Human Resources to complete an application. You may also wait until Open Enrollment in October to enroll for Aflac Cancer and/or Accident.

Initial if Declining Coverage

About Evidence of Insurability/Pre-Existing Limitations

Evidence of Insurability form must be completed if:

- You apply for an increase of Employee Supplemental Life.
- You decline Employee, Dependent Life or Disability coverage during your initial eligibility period and want it at a later date.

Note: If proof of good health is needed your life or disability coverage will not go into effect until approved by the carrier

IMPORTANT: You must read and sign to apply for coverage.

I understand that:

- I receive Group Life and optional Supplemental Life coverage under a Group Insurance policy provided and available to me by my employer. This coverage may be converted to a Whole Life policy when my employment terminates. Coverage may be ported if proof of good health is approved at higher age banded rates and will terminate at age 80.
- Disability insurance includes a 3/12 pre-existing limitation where that any condition received medical treatment, consultation, care or services including diagnostic, or took prescribed drugs or medication within 3 months prior to the effective date will not be covered for 12 months.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

Name a Beneficiary for Basic, Supplemental Group Life and Disability Insurance

On the lines below, list the individual(s) you want to receive Basic and Supplemental Life Insurance proceeds in the event of your death. You may specify as many individuals as you like but the total shares must equal 100%

Primary Beneficiary(ies) (Last, First, M.I) Must be at least age 18	Relationship	Total = 100%
		%
		%
Secondary Beneficiary(ies) (Last, First, M.I) Must be at least age 18	**Relationship**	**Total = 100%**
		%
		%

I UNDERSTAND that if my required contributions for the selected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect the change. Prior to the first day of each plan year, I will have the opportunity to change my benefit elections for the following plan year. If I do not complete and submit a new election form prior to a new plan year, I will be treated as having elected to continue my benefit elections then in effect for the new plan year. I understand all benefits listed will be deducted on a pre-tax basis, except Life, Disability and Critical Illness Insurance, unless I chose to opt out. I understand changes in the elected deduction and benefits can only be made in the event of a Section 125 qualifying event.

Employee Signature _____ **Today's Date** _____

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