Livingston EDUCATIONAL SERVICE Agency

2019 Election/Change of Status Form

Section 1 – Employee Information

Name: **Group: CLASSIFIED**

Section 2 — Benefits Selection *Please make your benefit selection in the following chart.*

HEALTH INSURANCE			
❖ Blue Cross Blue Shield – *Simply Blue PPO* o Deductibles: $1,350 Individual/$2,700 Family ❖ HSA and FSA eligible			☐ Single ☐ 2 Person ☐ Family
Single: $66.64/month $33.32/pay	2 Person: $331.91/month $165.96/pay	Family: $351.86/month $175.93/pay	
❖ Blue Care Network – *HMO Low* o Deductibles: $500 Individual/$1,000 Family ❖ FSA Eligible			☐ Single ☐ 2 Person ☐ Family
Single: $141.20/month $70.60/pay	2 Person: $510.86/month $255.43/pay	Family: $575.55/month $287.78/pay	
❖ Blue Care Network – *HMO High* o Deductibles: $1,350 Individual/$2,700 Family ❖ HSA and FSA eligible			☐ Single ☐ 2 Person ☐ Family
Single: $0.00/month $0.00/pay	2 Person: $65.61/month $32.81/pay	Family: $18.98/month $9.49/pay	
❖ Cash in Lieu: o $40/month $20/pay Must complete Waiver of Coverage			☐ I elect Cash in Lieu

Medical Waiver

(ONLY TO BE COMPLETED IF YOU ARE DECLINING MEDICAL COVERAGE)

ACKNOWLEDGMENT OF **DECLINED** OFFER OF GROUP HEALTH COVERAGE

I acknowledge that I have been given the opportunity to enroll in group health coverage offered by the CLIENT and decline the opportunity to enroll in this coverage. I understand that I will not have another opportunity to enroll in group health coverage offered by the District until the next open enrollment period or the date of a qualifying event (if any) permitting earlier enrollment, assuming that I am otherwise eligible to enroll in coverage at that time. I understand that, unless I have health coverage that satisfies my individual responsibility under the Affordable Care Act, I may be assessed a tax penalty for my failure to obtain coverage. I further understand that, even if I satisfy applicable household income requirements, I may not be eligible for a tax credit or subsidy for health coverage that I purchase on a health care exchange (Health Insurance Marketplace) for any month in which I was given the opportunity to participate in the District's group health coverage.

I understand that I must provide proof of other coverage by attaching a copy of my insurance card to this form in order to be eligible for any applicable contractual cash in lieu.

Employee Signature:_____ Date:_____

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❖ Dental – *Guardian*			☐ Single ☐ 2 Person ☐ Family ☐ Decline
Single: $11.29/month **$5.65/pay**	2 Person: $32.45/month **$16.23/pay**	Family: $32.45/month **$16.23/pay**	

❖ Vision – *Guardian VSP*			☐ Single ☐ 2 Person ☐ Family ☐ Decline
Single: $1.30/month **$.65/pay**	2 Person: $3.75/month **$1.88/pay**	Family: $3.75/month **$1.88/pay**	

I understand that:

-- I agree and consent to a reduction in my pre-tax compensation equal to the amount of the employee contribution premium costs for benefit coverages in accordance with my elections. I cannot change or revoke this benefit election agreement as of any date prior to the next January 1st unless I have a qualifying event.

-- **If I do not complete and return a new election form, I will be enrolled in the single Blue Care Network High Deductible Plan and responsible for the deductions associated with it.**

Employee Name: _____

Employee Signature:_____

Date:_____

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Certification of HSA Eligibility (Only Applies if Electing Simply Blue or HMO High Plan)

Only individuals who meet certain requirements are eligible to make contributions to a health savings account (HSA). To confirm that you meet those requirements and are eligible to make and receive contributions to an HSA please visit www.Livingstonesa.org Departments; Payroll, Finance, & Benefits Services; Enrollment

❖ **Health Savings Account (HSA) -** Employee Funding for Simply Blue and HMO High plans only.

Maximum Amounts for 2019
Single: $3,500 2P or Family: $7,000

Complete this section if you are funding your HSA for 2019.

Same deduction all year:

Per pay deduction $_____ x 24 Pays = Annual Deduction of $_____

Election for varied number of pays beginning 1/4/2019:

Per pay deduction $_____ ☐ Pays = Total Deduction of $_____

Per pay deduction $_____ ☐ Pays = Total Deduction of $_____

Total Annual Deduction: _____

HSA Authorization

_____ _____
Employee Signature Date

Employee Name:

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FLEXIBLE Spending Account (FSA) for eligible health care, prescription, dental and vision expenses

Maximum Amount for Plan Year 2019 is $2,650

Complete this section if you are funding your FSA for 2019.

Monies are front loaded.
Elections cannot be changed unless you have a qualifying event.

Per pay deduction $_____ x 24 Pays = Annual Deduction of $_____

DEPENDENT CARE FLEXIBLE Spending Account (FSA) for eligible child care expenses

Maximum Amounts for Plan Year 2019

Single or married filing separately: $2,500 **2P or Family: $5,000**

Complete this section if you are funding your FSA for 2019.

Monies are NOT front loaded.

Per pay deduction $_____ x 24 Pays = Annual Deduction of $_____

LIMITED FLEXIBLE Spending Account (FSA) for DENTAL AND VISION expenses ONLY

Maximum Amount for Plan Year 2019 is $2,650

Complete this section if you are funding your FSA for 2019.

Monies are front loaded.

Per pay deduction $_____ x 24 Pays = Annual Deduction of $_____

FSA Authorization

_____ _____
Employee Signature Date

Employee Name:

Life Insurance

All CLASSIFIED staff are eligible for a Life Insurance Policy equal to 1x your base Salary. We have recently had a change in carriers to Lincoln National and are requesting that you complete a new beneficiary form attached.

Please return this form with your open enrollment paperwork to Mary Dare.

The Lincoln National Life Insurance Company, PO Box 2649, Omaha, NE 68103-2649 toll free (800) 423-2765 Fax (800) 462-4660

www.LincolnFinancial.com

BENEFICIARY DESIGNATION FORM

Policyholder/Employer Livingston Educational Service Agency	Policy Number(s) Supplied by employer
Employee Name	Employee Social Security or Certificate Number xxx-xx-
Employee Address (Street, City, State)	Employee Telephone Number

WHO ARE YOUR BENEFICIARIES?

It is very important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). If multiple primary beneficiaries or contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. If more space is needed to list your beneficiaries please attach a sheet to this form. **The beneficiary(ies) named on this form will be valid for all basic, optional, and/or voluntary group term life and AD&D coverages unless otherwise indicated by you. The beneficiary designation may not go into effect until this form is signed and dated by you. Page 2 of this form includes examples of how to complete this form.**

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

Signature of Employee **Date**

COMPLETING YOUR BENEFICIARY DESIGNATION FORM

1. At the top of the form, fill in the information regarding your employer and yourself.
2. Next complete the information regarding who will be your primary and contingent beneficiaries. A primary beneficiary will be the person/people that you want to receive the life insurance benefit. The contingent beneficiary or beneficiaries will only receive the life insurance benefit if the primary beneficiary(ies) is no longer living. Indicate the percentage of the benefit amount that the beneficiary will receive. Do not use dollar amounts. Percentages must add up to 100%.
3. If you live in a community property state, are married and naming someone other than your spouse as the primary beneficiary, you should have your spouse sign this form to avoid any delays at claim time.
4. Sign and date the form.

Below is an example of how to complete the beneficiary designations:

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Jill Doe Address: 123 Main St, Anytown, NE 00000	xxx-xx-xxxx	Wife	xx/xx/xx	100%
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: John Doe Sr Address: 456 Main Ln, Anytown, NE 00000	xxx-xx-xxxx	Father	xx/xx/xx	50%
Name: Mary Doe Address: 789 Main Rd, Anytown, NE 00000	xxx-xx-xxxx	Sister	xx/xx/xx	25%
Name: Jack Doe Irrevocable Trust, Jill Doe TTEE UTA 1/04 Address: 123 Main St, Anytown, NE 00000	xxx-xx-xxxx	Trust		25%

FREQUENTLY ASKED QUESTIONS

Should I name a minor child as a beneficiary?

You may name a minor child as a beneficiary, however please be aware that we cannot make payment of a claim directly to a minor. If a claim is incurred we would need to make payment via UTMA or to the guardian of the minor's financial estate. Or, if guardianship is not obtained and if UTMA does not apply, the benefit will be placed On Hold - Age of Majority and payable once the minor reaches the age of majority.

How would I name a Charitable Organization as a beneficiary?

A charitable organization that is not your employer may be named as a beneficiary. You will need to indicate the name of the charitable organization, a contact for the organization, their tax identification number, and the percentage of the benefit that would be payable to them.

How do I name my Estate as the beneficiary?

You may name your estate as a beneficiary. To name your estate as the beneficiary indicate "My Estate" as the beneficiary. If you know who will be the executor or administrator of your estate you should also include that person's name. For example: My Estate, John Doe Executor.

How do I name a Trust as the beneficiary?

You may designate a trust as a beneficiary. To name a trust as a beneficiary, indicate Trustee (show Name and address) under Trust Agreement Dated (show date). If the trust has a tax identification number that will need to be supplied in place of the social security number. For example: Jack Doe Irrevocable Trust, Jill Doe TTEE UTA 1/1/04.

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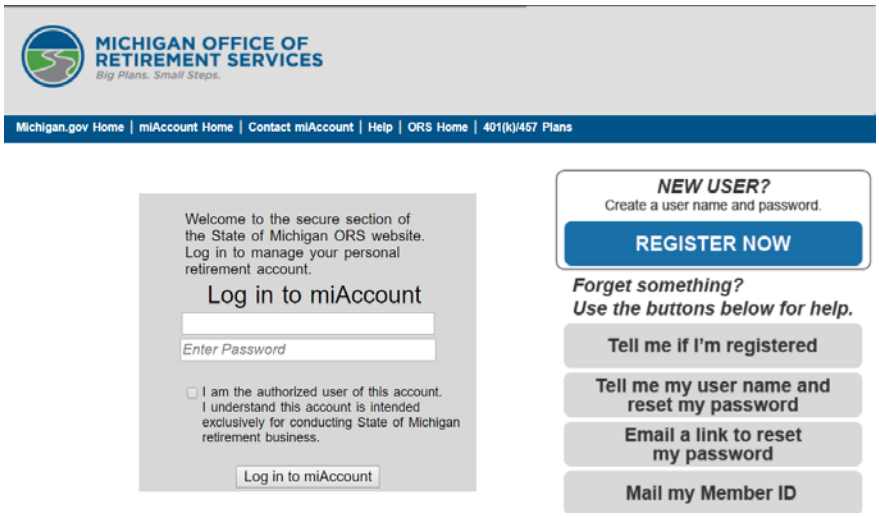
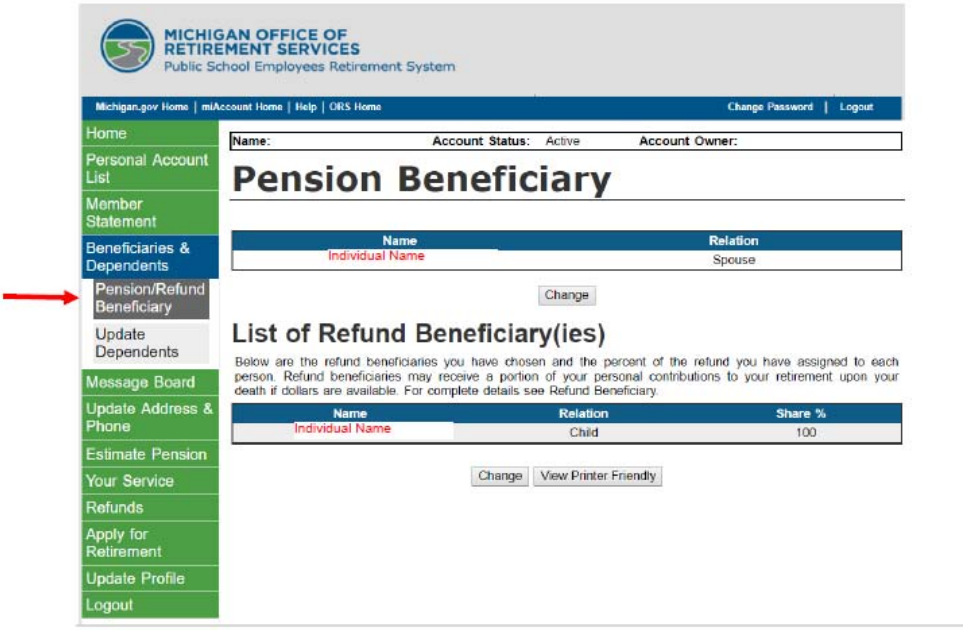
Office of Retirement Services – Beneficiary Elections

It is also a good time to update your beneficiary with Voya (if you have a Voya Account). You can do this at: https://stateofmi.voya.com.

You should also update your pension and refund beneficiaries with the Office of Retirement Services. To do this, go to your miAccount log on to www.michigan.gov/orsmiaccount



Once in your MiAccount, go to the Beneficiaries & Dependents Option on the left side and click on "Pension/Refund Beneficiary":



It is EXTREMELY important that you designate both your PENSION Beneficiary and your REFUND Beneficiary(s).

Your PENSION Beneficiary is the person that you will designate who would receive your pension based upon your death (typically a spouse). If you do not have one named prior to either retirement or death, then children up to age 18 will receive payments, however if no children your pension will revert to the State.

When Selecting your PENSION Beneficiary, you will have two options:

(1) I want to nominate a person as my beneficiary. I understand if I am married, I cannot use miAccount to name someone other than my spouse as my beneficiary. If I am married and want to name someone other than my spouse as my beneficiary, my spouse must relinquish his/her rights to any benefit by submitting by mail the *Beneficiary Nomination for Public School Employees*.

(2) I want the default provision of the retirement act to determine who will receive my survivor pension benefits. NOTE: Do not select the default provision if you are terminating employment. Instead, select the option above to nominate a person.

If you Select #1, you will have to indicate whether you are married or not. If you are then you are ONLY able to select your spouse, unless your spouse relinquishes their rights to your pension.

If you Select #2, The Default Provision reads as follows:

Default Provision

While you are actively employed, if a survivor pension is payable upon your death, the retirement act automatically provides a lifetime monthly survivor benefit to your spouse, or if not married, in equal payments to your unmarried children until they reach age 18.

When you go to designate your REFUND Beneficiary, you will have the option of selecting a Peson(s) OR an organization. If you do an organization you will need their TAX ID number. If you do a Person, you will need their Full Name, Date of Birth and Social Security Number.

This election is VERY important to designate, as it will allow any funds remaing upon your death to go to somewhere if your pension beneficiary has passed before you.