Benefit Enrollment Worksheet for the Period of 1/1/2018 through 12/31/2018

		Dollars paid by Employer per paycheck
Option A:	For Employees who elect a Medical Plan with ***Employee Only*** coverage	$77.00
Option B:	For Employees who elect a Medical Plan with ***Employee & Spouse*** coverage	$120.00
Option C:	For Employees who elect a Medical Plan with ***Employee & Child(ren)*** coverage	$119.00
Option D:	For Employees who elect a Medical Plan with ***Family*** coverage	$170.00

Medical Plans

Total Cost per Paycheck

	Plan Choices	Waiver	A	B	C	D	
Plan 1	$1000 Deductible		$156.08	$312.16	$280.94	$468.23	
Plan 2	$2000 Deductible		$138.12	$276.23	$248.61	$414.35	
Plan 3	$5000 Deductible		$133.68	$267.35	$240.62	$401.03	
Plan 4	$3500 HSA		$96.39	$192.78	$173.50	$289.17	

Dental Plan

Delta Dental

Waiver	A	B	C	D	
	7.68	15.12	15.66	27.09	

Vision Plan

VIPA

Waiver	A	B	C	D	
	1.78	3.56	3.56	4.71	

Accidental Death & Dismemberment	**No Cost**
Life Insurance Policy — 1 times Salary	**No Cost**

Line A: Add all Premiums above: _____

Line B: List Employer Contribution: _____

Line C: Subtract Line B from Line A
Employee Total Cost Per Paycheck: _____

Employee Name (Print): _____

Employee Signature: _____

Date: _____ Social Security Number: _____

I understand that the choices I have indicated on the worksheet must remain in effect for the entire plan year unless I have a change in family status.

A change in family status includes the birth of adoption of a child, marriage, divorce, death, spouse losing/gaining a job or employement status from part-time to full-time or full-time to part-time.

I hereby give my employer permission to reduce my salary by the above-elected amounts.
I understand that premiums I am obligated to pay for will be deducted from my pay on a before-tax basis.