Covenant Christian School

2019 Confidential Employee Information and Benefit Election Form

Employee Information

Benefits Effective Date: _____/_____/_____

Name _____ (first / mi / last)

SSN: _____

Address _____

Work: _____

Home: _____

Email: _____

(city / state / zip code)

Hire Date _____/_____/_____

Salary: $_____

Hourly ☐

Monthly Pay Period ☐

Annual ☐

Birth Date _____/_____/_____

Gender **M / F** (please circle)

Job Title _____

Dependent Information: *This information must be completed.*

Dependent Name:	MI	Relationship	Birth Date	M / F	SSN:
		Spouse			

Group Health Plan Benefits and Flexible Spending Account Elections:

** Please check the box next to each status for the benefit(s) you elect and/or write in your premium amount . Premiums listed will be "per monthly pay period", and will be pre-tax unless noted.*

HSA Health Plan with HRA:

The health insurance premiums are effective 01/01/2019.

Single	☐	$232.82	Employee/Child(ren)	☐	$761.53
Employee/Spouse	☐	$867.25	Family	☐	$1,373.67

☐ Decline Medical Plan

HSA Employee Contributions per pay period:

$ _____ Effective Date: _____/_____/_____

Pre-Tax	After-Tax
Decline	

Spending Account Elections: *Please indicate your dollar amount elections*

Medical FSA **The Plan year maximum is $2,700. (Minimum $0)**

Per Pay Period Election	Annual Election
$ _____	$ _____

Pre-Tax	After-Tax
Decline	

Special Medical FSA election: My spouse has an HSA and I elect to not cover my spouse under my Medical FSA.

Yes	No

Limited Purpose FSA** **The Plan Year maximum is $2,700. (Minimum $0)**

Per Pay Period Election	Annual Election
$ _____	$ _____

Pre-Tax	After-Tax
Decline	

**Compatible with the HSA and is for Vision / Dental / Preventive Services only.

Daycare FSA ($5,000 maximum)

Per Pay Period Election	Annual Election
$ _____	$ _____

Pre-Tax	After-Tax
Decline	

Authorization of Elections: I hereby make the above elections regarding the benefits available to me under the plan provided by my employer. I am further making an election to have my taxable compensation reduced by the amount equal to the value of the benefits elected on this form. For any benefit that I waive, I understand that I am not eligible to change my election until the next open enrollment unless I have a change of qualifying event.

X _____ _____

Employee Signature Date