Benefits Election Form January 1, 2023

FINLANDIA UNIVERSITY

Employee Information

Employee Name Address/City/State/Zip	Date of Birth Gender	Social Security Number Telephone Number

Dependent Name	DOB	SSN	Relationship	Sex	Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

Medical Election

☑ *I elect to enroll in the following BCBSM / BCN medical plan effective 1/1/2023*

Costs Shown Per Pay Period	Employee Only	Employee + 1 Dep	Family
BCSBM 1000 PPO Plan	☐ $126.66	☐ $303.99	☐ $379.98
BCBSM 2000 PPO HSA Plan	☐ $108.93	☐ $261.42	☐ $326.78
BCN 2000 HMO Plan	☐ $ 61.94	☐ $148.64	☐ $185.81
☐ **Waive Coverage**	**By initialing the Waive Coverage option, you certify that you have medical coverage elsewhere and are aware of any Federal tax liability as a result of the Individual Mandate under the Affordable Care Act.**		

Dental Election

☐ *Maintain my current dental plan election* ☐ *Enroll in the Delta Dental Plan effective 1/1/2023*

☐ Waive Coverage	Employee Only	Employee + 1 Dep	Family
Bi-Weekly Cost	☐ $12.55	☐ $24.44	☐ $49.88

Vision Election

☐ *Maintain my current vision plan election* ☐ *Enroll in the VSP Plan effective 1/1/2023*

☐ Waive Coverage	Employee Only	Employee + 1 Dep	Employee + 2 Dep	Family
Bi-Weekly Cost	☐ $4.32	☐ $7.27	☐ $7.42	☐ $11.96

Voluntary Benefits *(I would like more information about the following voluntary plans)*

	Short Term Disability	Long Term Disability	Voluntary Life
More information/rates	☐ Yes	☐ Yes	☐ Yes

Employee Authorization

I certify the above information to be correct and true to the best of my knowledge, and that the person(s) listed as Dependents qualify as my Dependents under the plan. I have elected to participate in the above listed employee benefit plans. I have checked the appropriate areas for each benefit. If I have elected to waive coverage, I have initialed the Waive Coverage areas. I agree that my compensation will be reduced be the amount of my required contribution towards the premiums for the benefit plans I have elected. I am responsible for any deductions that are missed. I authorize payroll to deduct the appropriate premiums from my paycheck. These rates are subject to change pending approval of coverage.

Your employer will not be responsible for expenses incurred for the plans that I have waived. I understand that I may not be allowed to participate with these plans, subject to IRS restrictions, until the next open enrollment period.

_____ _____

Employee Signature Date