EMPLOYEE INFORMATION FORM FOR BENEFITS

If you're submitting this electronically, be sure to first save a copy using your name.

Employee Name: Last, First, Middle	Sex (**M/F**)	Social Security Number	Date of Birth (mm/dd/yyyy)

MEDICAL INSURANCE ELECTION

☐ **Plan A – High Option** (similar to the Health Choice Plan)

Per-Pay Employee Payroll Contribution Rates

Employee	Emp+Spouse	Emp+Child(ren)	Family
$73.02	$168.24	$130.45	$214.52

☐ **Plan B – H.S.A. Compatible** (similar to the Health Saver plan)

Per-Pay Employee Payroll Contribution Rates

Employee	Emp+Spouse	Emp+Child(ren)	Family
$37.37	$85.59	$66.74	$109.55

☐ **Plan C – Base Plan** (new option for '23)

Per-Pay Employee Payroll Contribution Rates

Employee	Emp+Spouse	Emp+Child(ren)	Family
$22.35	$51.53	$40.09	$65.73

☐ **I waive Cairn medical insurance**

Please provide proof of other health insurance coverage to HR.

DENTAL INSURANCE ELECTION

☐ **Dental Premier PPO**

Per-Pay Employee Payroll Contribution Rates

Employee	Emp+Spouse	Emp+Child(ren)	Family
$14.65	$30.36	$37.10	$53.75

☐ **Dental Choice PPO**

Per-Pay Employee Payroll Contribution Rates

Employee	Emp+Spouse	Emp+Child(ren)	Family
$9.94	$20.94	$25.32	$37.26

☐ **DHMO** Please indicate a DHMO participating dentist, below*

Per-Pay Employee Payroll Contribution Rates

Employee	Emp+Spouse	Emp+Child(ren)	Family
$6.31	$10.68	$14.91	$17.54

*

☐ **I waive Cairn dental insurance**

PRE-TAX DEDUCTION AUTHORIZATION

Applies to employees who enroll in medical and/or dental insurance

☐ I ELECT the pre-tax option
☐ I DECLINE the pre-tax option
☐ Does not apply at this time

FLEXIBLE SPENDING ACCOUNT

Request & complete the FSA Enrollment Form

☐ I elect the Healthcare FSA
☐ I elect the Dependent Care FSA
☐ I waive participation in an FSA

403(b) RETIREMENT PLAN

Upon initial enrollment, additional forms are required. Once enrolled you can make changes to your contributions at any time. You may complete this section of the form, or email decision to human.resources@cairn.edu.

I authorize pre-tax salary reduction of this amount: ____ %
I authorize post-tax (Roth) salary reduction of this amount: ____ %
☐ I decline participation (or wish to stop contributing) *at this time.*

Dependent #1 **MEDICAL INSURANCE:** ☐ Cover ☐ Remove **DENTAL INSURANCE:** ☐ Cover ☐ Remove

Dependent Name: Last, First, Middle	Sex (**M/F**)	**Sp**ouse or **Ch**ild?	Social Security Number	Date of Birth (mm/dd/yyyy)

Dependent #2 **MEDICAL INSURANCE:** ☐ Cover ☐ Remove **DENTAL INSURANCE:** ☐ Cover ☐ Remove

Dependent Name: Last, First, Middle	Sex (**M/F**)	**Sp**ouse or **Ch**ild?	Social Security Number	Date of Birth (mm/dd/yyyy)

Dependent #3 **MEDICAL INSURANCE:** ☐ Cover ☐ Remove **DENTAL INSURANCE:** ☐ Cover ☐ Remove

Dependent Name: Last, First, Middle	Sex (**M/F**)	**Sp**ouse or **Ch**ild?	Social Security Number	Date of Birth (mm/dd/yyyy)

Dependent #4 **MEDICAL INSURANCE:** ☐ Cover X Remove **DENTAL INSURANCE:** ☐ Cover ☐ Remove

Dependent Name: Last, First, Middle	Sex (**M/F**)	**Sp**ouse or **Ch**ild?	Social Security Number	Date of Birth (mm/dd/yyyy)

Dependent #5 **MEDICAL INSURANCE:** ☐ Cover ☐ Remove **DENTAL INSURANCE:** ☐ Cover ☐ Remove

Dependent Name: Last, First, Middle	Sex (**M/F**)	**Sp**ouse or **Ch**ild?	Social Security Number	Date of Birth (mm/dd/yyyy)

Dependent #6 **MEDICAL INSURANCE:** ☐ Cover ☐ Remove **DENTAL INSURANCE:** ☐ Cover ☐ Remove

Dependent Name: Last, First, Middle	Sex (**M/F**)	**Sp**ouse or **Ch**ild?	Social Security Number	Date of Birth (mm/dd/yyyy)

______________________________ ______________ ______________________

EMPLOYEE SIGNATURE (not required if provided via Cairn email account) **DATE** **EFFECTIVE DATE OF CHANGE**