EMPLOYEE BENEFITS ENROLLMENT FORM

Employees already enrolled in NPA plans may enter name only in the top section, but please Check all choices on Page 1 and refresh all dependent information on Page 2. Finally, sign on Page 3. Please return to Steve Danner.

EFFECTIVE DATE OF COVERAGE:_____

FIRST NAME:_____LAST NAME:_____

SSN#: _____GENDER:_____ DOB:_____ MARRIED (y/n):_____

MAILING ADDRESS:_____CITY:_____STATE:_____ ZIP:_____

DATE OF HIRE:_____ OCCUPATION: _____ SALARY:_____

EMAIL: _____ PHONE NUMBER:_____

BCBSAZ - MEDICAL INSURANCE – HSA/HRA 1800HSA/600EE/3600HRA PLAN

MEDICAL PLAN (Check): ☐ Elect or ☐ Waive Coverage

IF ENROLLING, WHO DO YOU WANT TO COVER? (Check): ☐ Self only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self & Family

HEALTH EQUITY - HEALTH SAVINGS ACCOUNT

DO YOU WANT TO MAKE ADDITIONAL HSA CONTRIBUTIONS BEYOND THE STANDARD $100 CONTRIBUTED BY NPA AND $50 CONTRIBUTED BY EMPLOYEE?

(Check): ☐ Yes or ☐ No

IF YES, HOW MUCH DO YOU WANT TO CONTRIBUTE DURING 2024 BEYOND THE STANDARD $1800?

$_____ PER MONTH INTO YOUR HSA

(Total annual limit is $4150 for individuals and $8300 for families. The amount you enter here will be divided by 26 and deducted each paycheck. You may also take an incremental approach and request lump sums to be deducted at any point during 2024.)

DELTA DENTAL – DENTAL INSURANCE

ELECT DENTAL INSURANCE (Check): ☐ Elect or ☐ Waive coverage

IF ENROLLING, WHO DO YOU WANT TO COVER? (Check): ☐ Self only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self & Family

DELTA DENTAL - VISION INSURANCE

ELECT VISION INSURANCE (Check): ☐ Elect or ☐ Waive Coverage

IF ENROLLING, WHO DO YOU WANT TO COVER? (Check): ☐ Self only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self & Family

DEPENDENT INFORMATION (only fill in if electing coverage)

SPOUSE (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB ___________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

CHILD (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB:___________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

CHILD (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB:___________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

CHILD (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB:__________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

CHILD (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB:___________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

CHILD (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB:___________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

CHILD (fill in) First:_____________________________Last:______________________________SSN:___________________________Gender:_____DOB:___________

ELECT COVERAGES (Check): ☐ Medical ☐ Dental ☐ Vision

RELIANCE STANDARD – SHORT-TERM DISABILTY

YOU WILL AUTOMATICALLY BE ENROLLED IN THIS PRODUCT

RELIANCE STANDARD – VOLUNTARY LIFE INSURANCE (REFER to PLAN SUMMARY FOR RATES AND DETAILS)

WOULD YOU LIKE TO ELECT VOLUNTARY LIFE INSURANCE? (Check): ☐ Elect or ☐ Waive Coverage

Employee: $_____ *Spouse: $_____ *Child(ren): $_____

*cannot exceed 50% of the employee election, employee must enroll to elect coverage for spouse and child(ren).

PRIMARY BENEFICIARY:

First:_____ Last:_____ Relationship:_____ Phone Number:_____

SECONDARY BENEFICIARY:

First:_____ Last:_____ Relationship:_____ Phone Number:_____

INFINISOURCE – FLEXIBLE SPENDING ACCOUNT and/or DEPENDENT CARE ACCOUNT

WOULD YOU LIKE TO OPEN a FLEXIBLE SPENDING ACOUNT? (Check): ☐ Yes or ☐ NO

WOULD YOU LIKE TO OPEN a DEPENDENT CARE ACCOUNT? (Check): ☐ Yes or ☐ NO

If yes, please fill out the separate Infinisource Enrollment Form

Note on HSA Contributions: Of the $1800 in total annual HSA contributions, $900 ($600 from NPA, $300 from employee) will be deposited by NPA to Health Equity in January in advance, and the remaining $900 in August, while the employee will have their portion deducted from bi-weekly paychecks, in effect reimbursing NPA for the advance. Should an employee separate from NPA prior to the reimbursement, a lump deduction will be taken from final paycheck(s) to complete the reimbursement.

Submit by either:
(a) printing, completing, signing by hand, and giving to Steve, or
(b) filling all the applicable fields, putting your /John Hancock/ in the signature field below, printing to pdf, and emailing pdf to Steve.

Employee Signature: _____ **Date:** _____

FINISHED, YAY!!!

NPA BENEFITS -- RATE SHEET FOR 2024 (12/1/23-11/30/24)

MEDICAL BCBS HSA6000 HSA/HRA PLAN

Payment Sources/Sequence:

- **First $1800: HSA with Annual Contributions of $1800**
- **Next $600 ($1801-$2400): Employee Out of Pocket (Effectively a Deductible)**
- **Next $3600 ($2401-$6000): Reimbursed by NPA after EOB Processed by Benefit Commerce Group**
- **Above $6000: Covered by BCBS at 100%**

Coverage(s) You Are Taking:	Total Annual Cost (Premiums + HSA + est. HRA costs)	NPA pays	You pay/contribute	Employee Deduction Each Pay Period
Employee (incl. $1800 joint HSA contrib.)	**$7,915**	**$6,255** (includes company HSA contribution of $1,200)	**$1,660** ($1,060 + $600)	**$63.86** (includes $40.78 in premium plus your own $23.08 HSA contribution)
Add Spouse (no HSA automatically included)	**$6,182**	-	**$6,182**	**Add'l $237.77**
Add All Children (no HSA automatically included)	**$5,189**	-	**$5,189**	**Add'l $199.57**

DENTAL – DELTA DENTAL

	Total Annual Premium Cost	NPA pays	You pay	Employee Deduction Each Pay Period
Employee	**$603**	**$482**	**$121**	**$4.63**
Add Spouse	**$660**	-	**$660**	**Add'l $25.38**
Add All Children	**$609**	-	**$609**	**Add'l $23.42**

VISION – DELTA VISION (EYEMED)

	Total Annual Premium Cost	NPA pays	You pay	Employee Deduction Each Pay Period
Employee	**$91.68**	**-**	**$91.68**	**$3.53**
Add Spouse	**$91.92**	**-**	**$91.92**	**Add'l $3.54**
Add All Children	**$87.36**	**-**	**$87.36**	**Add'l $3.36**
Add All Family	**$188.28**	**-**	**$188.28**	**Add'l $7.24**