FAXON ACADEMY

Payroll Deduction Form
To Be Returned to HR

Payroll Deduction Authorization
Plan Year: 01/1/2022 – 12/31/2022

SECTION 1: EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DOB (MM/DD/YY)	GENDER	MARITAL STATUS
		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed

MAILING ADDRESS		
CITY	STATE	ZIP

EMAIL ADDRESS:	HOME AND/OR MOBILE PHONE NUMBER:

SECTION 2: BENEFIT SELECTION - IF DECLINING MEDICAL COVERAGE, PLEASE COMPLETE SECTION 4

BLUE CROSS BLUE SHIELD - SELECT COVERAGE TYPE	**FOR 20 PAYROLL DEDUCTIONS**	**FOR 24 PAYROLL DEDUCTION**
☐ BCBSM SIMPLY BLUE PPO $1,000 (Medical Only)	**(20 Pay)Select one:** ☐ Single - $151.39 ☐ Double - $526.52 ☐ Family - $694.16	**(24 Pay)Select one:** ☐ Single - $126.16 ☐ Double - $438.77 ☐ Family - $578.47
BLUE CARE NETWORK - SELECT COVERAGE TYPE	**FOR 20 PAYROLL DEDUCTIONS**	**FOR 24 PAYROLL DEDUCTION**
☐ BCN HMO $1000 HMO (Medical Only)	**(20 Pay)Select one:** ☐ Single - $80.40 ☐ Double - $275.75 ☐ Family - $367.20	**(24 Pay) Select one:** ☐ Single - $67.00 ☐ Double - $229.80 ☐ Family - $306.00
BLUE CARE NETWORK – HMO HDPD HSA New Plan	**FOR 20 PAYROLL DEDUCTIONS**	**FOR 24 PAYROLL DEDUCTION**
☐ BCN HMO, HDHP HSA $1,400 Deductible ☐ With HSA Account ☐ Without HSA (due to Medicare and/or Medicaid)	**(20 Pay)Select one:** ☐ Single - $48.97 ☐ Double - $200.31 ☐ Family - $272.89	**(24 Pay) Select one:** ☐ Single - $40.81 ☐ Double - $166.93 ☐ Family - $227.41
☐ **Voluntary Dental- BCBSM** If you waived medical coverage with Faxon, and are not enrolled in a medical plan elsewhere, you cannot elect Voluntary dental or Voluntary Vision	**(20 Pay) Select one:** ☐ Single - $ 18.88 ☐ Double - $37.76 ☐ Family - $66.08	**(24 Pay) Select one:** ☐ Single - $15.73 ☐ Double - $31.47 ☐ Family - $55.07
☐ **Voluntary Vision- BCBSM** If you waived medical coverage with Faxon, and are not enrolled in a medical plan elsewhere, you cannot elect Voluntary dental or Voluntary Vision	**(20 Pay) Select one:** ☐ Single - $4.00 ☐ Double - $8.00 ☐ Family - $13.28	**(24 Pay) Select one:** ☐ Single - $3.34 ☐ Double - $6.67 ☐ Family - $11.07

METLIFE VOLUNTARY		
SELECT COVERAGE TYPE BELOW:	*MetLife Enrollment form must be completed for NEW elections	
☐ **VOLUNTARY LIFE WITH AD&D** – Check this box. Enter total amount from worksheet of Open Enrollment guide	**Per 20 Payroll Deductions:** **$**_____	**Per 24 Payroll Deductions:** **$** _____
☐ **VOLUNTARY SHORT-TERM DISABILITY**- Check this box. Enter total amount from worksheet of Open Enrollment Guide	**Per 20 Payroll Deductions:** **$**_____	**Per 24 Payroll Deductions:** **$** _____

SECTION 3: ACKNOWLEDGEMENTS, AUTHORIZATIONS AND SIGNATURE

I, hereby request the amount(s) and form(s) of the coverage for which I am eligible under the plans of my employer and I authorize same to deduct the required contribution, if any, from my earnings. I further certify that the statements herein are complete and accurate to the best of my knowledge. I understand benefits could be affected, reduced, or terminated if I knowingly provide false, incomplete, or misleading information on this form. I understand and agree that, under no circumstances, does this form extend the obligations of the plan to benefits that would otherwise be outside the scope of the plan document. I understand and agree that this form does not create any contractual rights or obligations between the plan and other parties to plan benefits that would otherwise be outside the scope of the plan document. The language within the plan document controls the operation of the plan.

Authorization to receive Federal Notices: I have received all required Federal notices in the current Open Enrollment booklet and I hereby give permission for any and all Federal or State required notices to be sent to me electronically. I also understand that I have access to the notices on the intranet. If I would like to request a paper copy of any notices, these are available to me by contacting my HR Department.

Authorization to release information: I hereby give permission that any providers of healthcare services, claim administrators, insurers, reinsurers and others who have a legitimate need for such information for the purpose of review, investigation or evaluation of a claim, to supply each other with information about my (or my covered dependent participants, if applicable) health status and the healthcare services provided to me (or my covered dependent participants, if applicable). I agree that a photographic copy of this permission is as valid as the original.

Signature _____ Date_____

SECTION 4: DECLINING COVERAGE (MUST PROVIDE PROOF OF OTHER COVERAGE – PLEASE SUBMIT COPY OF ID CARD)

Authorization to receive Federal Notices: I have received all required Federal notices in the current Open Enrollment booklet and I hereby give permission for any and all Federal or State required notices to be sent to me electronically. I also understand that I have access to the notices on the intranet. If I would like to request a paper copy of any notices, these are available to me by contacting my HR Department.

I, certify that I have been given the opportunity to examine the benefits available to me and the opportunity to enroll in my employer's Plan(s).

After careful consideration, I have decided to decline the benefits for which I am, or may be eligible because

- ☐ I'm covered on my spouse's plan
- ☐ I'm purchasing individual insurance on the exchange
- ☐ I'm under 26 years of age AND covered on my parent's insurance
- ☐ Other _____

I understand that if, in the future, I wish to participate in the coverages herein declined, I will have to wait until the next Open Enrollment Period unless there is a qualifying life event, such as marriage, divorce, birth, or adoption. Human Resources must be notified within 30 days of a qualifying life event.

Print Name _____

Signature _____ Date_____