Atlantic Community Charter School
2023-2024 Medical & Dental Payroll Deduction Authorization Form

1. Employee Information	Please provide all requested information		
Full Name:	*Social Security Number:*	*Marital Status:* ☐ Single ☐ Married ☐ Divorced/Separated	
Address:	*Date of Birth:*	*Gender:*	*Date of Hire:*
City: *State:* *Zip:*		*Daytime Phone Number:*	

2. Type of Enrollment		Please check (✓) one	
☐	New Hire Enrollment	☐	Birth or Adoption of Child
☐	Open Enrollment	☐	Divorce / Legal Separation
☐	Address Change Only	☐	Spouse lost or gained coverage
☐	Marriage	☐	Other (please indicate): _____

3. Medical/Rx/Vision Benefit Options	Please check (✓) benefit/family coverage you are selecting				
Horizon BCBS of New Jersey	**Waive**	**EE Only**	**EE + Child(ren)**	**EE + Spouse**	**EE + Family**
EPO Design 1 w/ Horizon Vista IV	☐ **$0**	☐ $51.66	☐ $153.17	☐ $278.61	☐ $437.79
OMNIA Design 1 w/ Horizon Vista IV		☐ $42.87	☐ $125.97	☐ $229.68	☐ $361.27
Direct Access NJ EHP w/ Horizon Vista IV*		☐ $_____	☐ $_____	☐ $_____	☐ $_____

**Please see following page to calculate contributions.*

5. Dental Benefit	Please check (✓) benefit/family coverage you are selecting				
United Concordia	**Waive**	**EE Only**	**EE + Child(ren)**	**EE + Spouse**	**EE + Family**
	☐ **$0**	☐ $2.47	☐ $10.92	☐ $12.58	☐ $23.02

5. Life & Disability	Basic Life/AD&D, Short Term & Long Term Disability is provided 100% by ACCS at no cost to the employee
Mutual of Omaha	****Please remember to update your beneficiary information annually ****

AUTHORIZATION – Important! Read the statement below.

My signature below indicates that I have read and understood this Enrollment & Authorization Form and the descriptive materials made available to me under the ACCS Benefits Program. I understand that this salary reduction authorization can only be changed during initial enrollment periods, unless I have a change in family status as defined by law. I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge.

Employee Signature **Date**

SPECIAL ENROLLMENT NOTICE

IRS §125 prohibits you from changing your enrollment during the Plan Year unless you experience a qualifying life event. A qualifying event includes a marriage, divorce, death of a spouse or a dependent, birth or adoption of a child, termination, or commencement of employment for your spouse, a change in employment status (full-time to part-time or part-time to full-time) for you or your spouse that affects benefits eligibility, or taking an unpaid, medical leave of absence by either you or your spouse. If you experience one of these qualifying events, you are obligated to notify the Human Resources Department within 30 days. Failure to do so may affect benefits coverage.

How to calculate your contributions

Salary	Coverage Level Percentages			
	Single	EE + Child(ren)	EE + Spouse	EE + Family
$40,000 or Less	1.8%	2.3%	2.9%	3.4%
>$40,001 to $50,000	2.0%	2.6%	3.4%	4.0%
>$50,001 to $60,000	2.3%	2.9%	4.0%	4.5%
>$60,001 to $70,000	2.6%	3.1%	4.5%	5.2%
>$70,001 to $80,000	2.9%	3.4%	5.2%	5.7%
>$80,001 to $90,000	3.1%	3.7%	5.7%	6.2%
>$90,001 to $100,000	3.4%	4.0%	6.2%	6.8%
>$100,001 to $125,000	3.7%	4.5%	6.8%	7.4%
More than $125,000	Percentage to be contributed shall be the same as for a base salary/allowance of $125,000.			

1. Enter your annual salary: $_____

2. Take your salary and multiply by the applicable percentage above, based on your salary and enrollment tier

$_____ x _____% = $_____

3. Divide the resulting amount by 24 pays

$_____ / 24 = $_____

4. Take the resulting amount and add the applicable vision contribution from the below table

Vision Plan	Single	EE + Child(ren)	EE + Spouse	EE + Family
Horizon Vista IV	$0.22	$0.90	$1.23	$2.00

$_____ + $_____ = $_____

5. The resulting amount is your per pay contribution for medical, prescription drug, and vision. Please enter this amount on the previous page next to the box you checked.