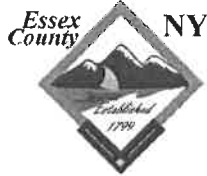


Personnel Department

Jennifer Mascarenas

Personnel Officer

PO Box 217 7551 Court Street
Elizabethtown NY 12932



Erica Sadowski- Personnel Technician/Deputy
Jaime Douglass- Personnel Technician
Christina Slattery- Personnel Clerk

Phone: (518) 873-3360 Fax: (518) 873-3372

2023 WAIVER OF HEALTH INSURANCE COVERAGE BUY-OUT INCENTIVE

Please be advised that I _____, waive my rights to health insurance coverage with Essex County and release the County from any other health related liability.

I understand that I may be eligible for a buy-out program and that in order to qualify I must submit documentation that other health insurance coverage is provided for me.

Print Name

Employee Signature

Date

NOTE: You must attach documentation indicating that you have other health insurance coverage for the Year 2023 to receive this benefit. Your proof of insurance coverage must list you as a subscriber or dependent on the plan. Benefits may be verified on a case by case basis.



The Preferred Group

PO Box 15136
Albany, NY 12212-5136
(866) 989-8995

Check out your Account Information Online

FSA Enrollment Form



WLT10065

Change Type:

- Address/Name Change
- New Hire
- Termination (Complete COBRA Form)

Date of Event: ___/___/___

- Change in Status
- Unpaid Leave of Absence
- Return from Leave of Absence

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information — Please Read, Fill Out Carefully & Return to Personnel Office

Employer Group # 10065	Employer Group Name Essex County	Plan Year 01/01/2023- 12/31/2023	Social Security Number - -
Employee Name (First Name)		(Last Name)	
Employee Address (Street, Apt. #)			Date of Birth (mm/dd/yyyy) / /
Employee Address (City, State, Zip Code)			
Home Phone	Cell Phone	Email Address (Please allow email from benefitsinfo@thepreferredgroup.com)	

Section 2 Flexible Spending Plan Benefit Elections

I am enrolled in the Essex County's Medical Insurance Premium Plan, and elect to have my portion of medical premiums paid on a pre-tax basis, for this and subsequent years.

I am enrolled in Essex County's Medical Insurance Premium Plan, but do NOT elect to have my portion of medical premiums paid on a pre-tax basis, for this and subsequent years.

I elect NOT to participate in the Essex County's unreimbursed medical and dependent day care plan.

Account Type	Fund#	Prior Election	New Election	# of Pay Periods	Total Bi Weekly Deduction
MEDICAL FSA (\$3050 max)	1	\$0.00			
DEPENDENT DAY CARE (\$5,000 max/\$2,500 if married, filing separately)	2	\$0.00			
Buy Out			Cash	Unreimbursed Medical	Dependent Daycare
Buy Out Incentive (\$3,000 Individual, \$5,000 Family)					

Section 3 Dependent Information / Reimbursement Options

Dependent Names on File	(Please add dependents through the Online Portal)
Reimbursement Method	Add Direct Deposit, Bank Routing # _____, Account # _____
Debit Card	(Must have a valid email address) Initial to Request Debit Card _____

Please note: By entering the above information you are enrolling into these specified programs and are validating your dependent information. For more information on these options including the timing of reimbursements, please see your Summary Plan Description.

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules

Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I am only entitled to the amount of the above elections and cannot change any of my elections during the plan year (unless I have an acceptable change in status), and that any money left in my account(s) at the end of the plan year will be forfeited.

Employee Signature	Date
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Section 5 Employer's Section — Payroll Information for Salary Reduction Changes

Payrolls **26**

Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct
FSA				
DCA				

Use 'First Payroll Date' and employer signature ONLY if the employee is making a mid-year election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an old election or termination.

Employer Signature	Date
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