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 CONTRIBUTION WAIVER REQUEST FORM FOR DOMESTIC PARTNERSHIP - BOTH EMPLOYED BY ESSEX COUNTY WITH BENEFITS AFTER 01/01/2009

Essex County has agreed that "for Domestic Partners who both are employees of the County after January 1, 2009 the County shall pay 90% of the plan costs, for all years of the contract."

AUTHORIZATION:

Our health insurance option choice requires us to contribute to the premium cost of our plan. We would like to request that the contribution amount of our health insurance plan be 10% of the plan costs due to both of us being employed by Essex County and are Domestic Partners after January 1, 2009.

We understand that if one of us was to terminate employment with Essex County or our Domestic Partnership status changes, we would once again be required to contribute to the premium cost as may be necessary at the time of the change.

We hereby authorize payroll deductions for the following Health Insurance Plan with Essex County:

- ☐ **PPOJ - One (1) Individual Plan - $110.14 monthly**
- ☐ **PPOJ - One (1) 2 Person Plan - $182.86 monthly**
- ☐ **PPOJ - One (1) Family Plan - $236.86 monthly**
- ☐ **SIMPLY BLUE 40-0 - One (1) Individual Plan - $103.62 monthly**
- ☐ **SIMPLY BLUE 40-0 - One (1) 2 Person Plan - $173.08 monthly**
- ☐ **SIMPLY BLUE 40-0 - One (1) Family Plan - $223.38 monthly**

☐ **After-Tax Deduction**

Employee's Signature	**Domestic Partner Signature**
Print Name	**Print Name**
County Department	**County Department**
Date	**Date**
☐ **Subscriber**	☐ **Subscriber**

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CHOICE OF HEALTH INSURANCE COVERAGE FOR 2023

I have reviewed the Excellus Detail Plan Comparison for the two health insurance options being offered by Essex County for the Year 2023. I have compared the benefits of the PPOJ and the Simply Blue 40-0 plans and feel the best plan for me for 2023 is as follows:

☐ **I choose the PPOJ Plan for the Year 2023.**

☐ **I choose the Simply Blue 40-0 Plan for the Year 2023.**

_____

Print Name

_____ _____

Signature **Date**

NOTE: An application form will need to be completed only if you are making changes to your current plan. (adding or deleting members, changing or terminating coverage, etc.) The enrollment and termination forms can be sent by the Personnel Office or found on our website: https://www.co.essex.ny.us/wp/personnel-and-civil-service/?target=Forms

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2023 PREMIUM ENHANCEMENT PROGRAM
FULL-TIME BENEFIT EMPLOYEES

☐ I elect NOT to participate in the Premium Enhancement Programs for the Year 2023.

☐ I elect to exchange 5 days of my accrued vacation and/or sick leave in return for a credit of $900.00 to be applied toward my share of the Health Insurance Premiums on a monthly basis. I understand that I must have had at least 15 days of combined sick leave and vacation time on October 31, 2022 to be eligible for the enhancement.

_____ Sick Leave Hours to be contributed
_____ Vacation Leave Hours to be contributed
_____ Total Leave hours to be contributed *

*NOTE: Total Leave to be contributed must equate to 5 days of leave time.

☐ I am a 12 hour a day employee and elect to exchange 40 hours (3.4 days) of my accrued vacation and/or sick leave in return for a credit of $900.00 to be applied toward my share of the Health Insurance Premiums on a monthly basis. I understand that I must have had at least 15 days of combined sick leave and vacation time on October 31, 2022 to be eligible for the enhancement.

☐ I have 10 or more years of benefit service with Essex County and wish to exchange 1 additional day (0.66 of a day for 12 hour employees) of sick leave in return for a credit of $180.00.

☐ I elect to use a portion of my 2023 Longevity Payment toward my share of the Health Insurance premiums on a monthly basis.

_____ 2023 Longevity Payment Entitled Amount
_____ Percentage of Longevity Payment to be contributed **
_____ Amount of Contribution
_____ County Contribution (30% match)

**NOTE: Percentage can be 10% to 80% of the entitled Longevity Payment. The County will match 30% of the contributed amount.

***** A signed October 2022 Time Sheet must be submitted with this form. *****

Print Name **Date**

Employee Signature

Personnel Office Use Only	☐ Approved by _____

Date: Thursday October 20, 2022

From: Preferred Group Plans Benefits Services

To: Essex County FSA Plan Eligible Employees

We are pleased to announce that it's open enrollment time for the Essex County FSA Plan administered by The Preferred Group! The Preferred Group with its same day processing and quick response live phone coverage will answer your inquiries and handle your claims quickly and efficiently.

The Essex County FSA Plan Year will run from 1/1/2023 to 12/31/2023 for the coming year. The health portion of your account is pre-funded by the County. This means if you elected the maximum amount to fund your account, ($3,050 max), would be available to you on 1/1/2023. The Dependent Day Care account is funded only by the monies deducted from your paychecks and will only have the available funds up to the amount that you have deposited ($5,000max/$2,500if married, filing separately). As it has been in prior years, you will have 90 days after 12/31/2022 to submit claims for bills with dates of services prior to 12/31/2022.

The Essex County FSA Plan allows employees to put money away to pay for out-of-pocket medical and Dependent Day Care expenses on a pre-tax basis. **This lowers your taxable income and saves you money.**

This plan will be able to have reimbursement claims filed by mail, fax, or online submission. If you are interested, you can sign up to receive a **benefit debit card** to use at the pharmacy, doctors office or hospital. Please remember that you will need to save all receipts for expenses for which you are being reimbursed through the FSA plan. There is a reimbursement voucher in your enrollment kit or you can download one at www.thepreferredgroup.com and select "Resources" and "Forms". All vouchers submitted for Reimbursement must contain the following; date of service, description of service or product, amount, provider's name and address. All Dependent Care Claims must include the provider's Tax I.D. or Social Security number.

In the event of a termination there is a 90 day filing period in which to submit eligible expenses for reimbursement as of the date that you had been terminated from service.

All paper claims should be sent to The Preferred Group, PO Box 15136, Albany, NY, 12212-5135. Please remember, once registered on the benefits portal you will be able to submit your claims and scanned receipts into the secure messaging section. We also accept your manual claims by fax at (518) 641-0325. Our Benefit Services line is (866) 989-8995 and we will be happy to answer any of your questions.

The Preferred Group Benefit Services line is available Monday thru Friday 8 am – 4:30 pm.

Important Information Regarding the Current Plan Year for the Participants

The deadline for submission of current plan year claims is **90 days** after 12/31/2022. Your current Debit Card will remain in effect until the **expiration date** listed on the card. In order to receive any remaining current plan year funds left in your current FSA account after the 12/31/2022 deadline, you will need to submit a paper claim to The Preferred Group.

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: **Date of Event:** ____/____/____

- ☐ Address/Name Change
- ☐ New Hire
- ☐ Termination (Complete COBRA Form)
- ☐ 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 #	Employer Group Name	Plan Year	Social Security Number
10065	Essex County	01/01/2023- 12/31/2023	- -

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

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				

Employer Signature	Date

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.

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: **Date of Event:** ____/____/____

- ☐ Address/Name Change
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- ☐ Termination (Complete COBRA Form)
- ☐ 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 #	Employer Group Name	Plan Year	Social Security Number
10065	Essex County	01/01/2023- 12/31/2023	___-___-___

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)

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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 _____

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The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(800) 573-7474
www.thepreferredgroup.com

Request for the Prepaid Benefits Card

Employer Name: _____

Participant Name: _____

SSN: _____

Participant Email Address **(Required)**: _____

Date of Birth: _____

The benefit card(s) are to be used for eligible expenses allowed through my employer's plan. I further understand that I am solely responsible for the validity of the charges and **I am to retain all originals or copies of all documents of which charges appear on the debit card.** I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health coverage or if the charges are deemed to be unreimbursable, I shall return the monies paid to me by this plan, for re-crediting of my account.

I will have on-line access to my account information. General communications regarding my account and any requests for the substantiation of charges will be done via email. Requests for the substantiation of charges that are not answered/validated may result in card suspension.

I will receive two (2) benefit cards that will expire after three years. I understand the information below **must contain my spouse and/or dependent information** in order to obtain a second benefit card. **Funds will automatically be reloaded each plan year unless you submit a Termination Request form.** Cards will be received in 7-10 business days from date of enrollment. I understand that a fee of $18.00 per year will be deducted from my account at the beginning of the plan year.

Dependent Name: _____

Dependent SSN: _____

Date of Birth: _____

Home Address: _____

_____

Relationship to Participant: _____

Please see reverse side for dependent information

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