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 REQUEST FORM FOR PARENT AND DEPENDENT WHEN BOTH ARE EMPLOYED BY ESSEX COUNTY AND BOTH ELIGIBLE FOR BENEFITS AFTER 2009

For County Employees who are required under the Patient Protection and Affordable Care Act to provide "coverage for dependents under 26 years old" and both are employees eligible for benefits with the County shall contribute 10% of the plan costs.

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. We are both employees of Essex County and meet the criteria of parent and dependent child under the age of 26.

We understand that if one of us was to terminate employment with Essex County or no longer meet the under age 26 requirement as a dependent, we would 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) Famil☐ SIMPLY BLUE 40-0	son Plan - \$182.86 monthly ly Plan - \$236.86 monthly - One (1) 2 Person Plan - \$173.08 monthly - One (1) Family Plan - \$223.38 monthly
☐ Pre-Tax Deduction ☐ After-Tax Deduction	
Parent's Signature	Child's Signature
Print Name	Print Name
County Department	County Department
Date	Date

Personnel Department

Signature

Jennifer Mascarenas
Personnel Officer
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Elizabethtown NY 12932



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Date

CHOICE OF HEALTH INSURANCE COVERAGE FOR 2023

insurance of compared the	lewed the Excellus Detail Plan Comparison for the two health positions being offered by Essex County for the Year 2023. I have the benefits of the PPOJ and the Simply Blue 40-0 plans and feel the reme 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.
Prix	nt Name

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

	proved by
Employee Signature	
Print Name	Date
*** A signed October	2022 Time Sheet must be submitted with this form. ***
will match 30% of the contri	
**NOTE: Percentage can 1	be 10% to 80% of the entitled Longevity Payment. The County
	County Contribution (30% match)
-	Amount of Contribution
	Percentage of Longevity Payment to be contributed **
Health Insurance pro	emiums on a monthly basis. 2023 Longevity Payment Entitled Amount
	rtion of my 2023 Longevity Payment toward my share of the
	ears of benefit service with Essex County and wish to exchange 66 of a day for 12 hour employees) of sick leave in return for a
accrued vacation an toward my share of that I must have had October 31, 2022 to	ay employee and elect to exchange 40 hours (3.4 days) of my d/or sick leave in return for a credit of \$900.00 to be applied the Health Insurance Premiums on a monthly basis. I understand at least 15 days of combined sick leave and vacation time on be eligible for the enhancement.
*NOTE: Total Leav	ve to be contributed must equate to 5 days of leave time.
	Total Leave hours to be contributed *
	Vacation Leave Hours to be contributed
	Sick Leave Hours to be contributed
credit of \$900.00 to on a monthly basis.	be applied toward my share of the Health Insurance Premiums I understand that I must have had at least 15 days of combined on time on October 31, 2022 to be eligible for the enhancement.
	5 days of my accrued vacation and/or sick leave in return for a
I place NOT to partic	ipate in the Premium Enhancement Programs for the Year 2023.

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 <u>benefit debit card</u> to use at the pharmacy, doctors office or hospital. Please remember that you will need to save <u>all</u> 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 <u>www.thepreferredgroup.com</u> 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 <u>must</u> 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.

PREFERRED The Preferred Group

Employer Signature

FSA Enrollment Form



	ROUP (866) 989-8995 Check out your Account Information Online				lete COBRA Form)	Date of Event:// ☐ Change in Status ☐ Unpaid Leave of Absence ☐ Return from Leave of Absence			
DIRECTION	NS: Employee Employer		ions 1, 2, 3 nge Type' l	and 4 then Box and com	eturn to your emplo plete Section 5	oyer.			
Section 1	Employee In	formation — Pleas	e Read, F	ill Out Care	efully & Return t	o Personn	el Office		
Employer Group			,		Plan Year		Social Se	curity Num!	per
10065	Essex C	ounty		0 + 1	01/01/2023- 1	2/31/2023			•
Employee Nam	e (First Name)			(Last Nam	e)				
Employee Addre	ess (Street, Apt. #)	- 1					Date o	f Birth (mm.	/dd/yyyy)
								//	
Employee Addre	ess (City, State, Zip	Code)							
Home Phone		Cell Phone		Email Add	ress (Please allow emai	I from benefitsinfo@thepreferredgroup.com)			
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Debit Card		cilian addicas)		Debit Card					
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Section 4	Signature and	d Acceptance of Ru	les of Fle	kible Spend	ling Plan Rules				
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Date

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PREFERRED The Preferred Group

Employer Signature

FSA Enrollment Form



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Date

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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. If turther understand that I am solely responsible for the validity of the charges and I am to retain all priginals 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.
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.
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 fermination Request form. Cards will be received in 7-10 business days from date of enrollment, 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