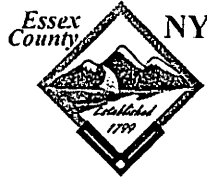


Personnel Department

Jennifer Mascarenas
Personnel Officer
PO Box 217 7551 Court Street
Elizabethtown NY 12932



Erica Sadowski- Personnel Technician/Deputy
Jaime Douglass- Personnel Technician
Bridget Moran- Personnel Clerk

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

CHOICE OF HEALTH INSURANCE COVERAGE FOR 2022

I have reviewed the Excellus Detail Plan Comparison for the two health insurance options being offered by Essex County for the Year 2022. I have compared the benefits of the PPOJ and the Simply Blue 40-0 plans and feel the best plan for me for 2022 is as follows:

- I choose the PPOJ Plan for the Year 2022.

- I choose the Simply Blue 40-0 Plan for the Year 2022.

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>

Personnel Department



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2022 CONTRIBUTION WAIVER REQUEST FORM FOR DOMESTIC PARTNERSHIP - BOTH EMPLOYED BY ESSEX COUNTY PRIOR TO 01/01/2009

Essex County has agreed that "for Domestic Partners and both are employees of the County prior to January 1, 2009 the County shall pay 100% 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 waived due to both of us being employed by Essex County prior to January 1, 2009.

We understand that if one of us was to terminate employment with Essex County or our 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.

Domestic Partner Signature

Domestic Partner Signature

Print Name

Print Name

County Department

County Department

Date

Date

Subscriber

Subscriber



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 01/01/2022- 12/31/2022	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 (\$2750 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				

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
--------------------	------



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: ___/___/___
<input type="checkbox"/> Address/Name Change	<input type="checkbox"/> Change in Status
<input type="checkbox"/> New Hire	<input type="checkbox"/> Unpaid Leave of Absence
<input type="checkbox"/> Termination (Complete COBRA Form)	<input type="checkbox"/> 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 01/01/2022- 12/31/2022	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)	

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 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 (\$2750 max)	1	\$0.00			
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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.

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Employee Signature	Date
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Section 5 Employer's Section — Payroll Information for Salary Reduction Changes # Payrolls: 26

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FSA				
DCA				

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Employer Signature	Date
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