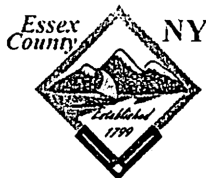
Personnel Department

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

2022 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) 2 Person Plan - $182.86 monthly
- ☐ PPOJ - One (1) Family Plan - $236.86 monthly
- ☐ SIMPLY BLUE 40-0 - One (1) 2 Person Plan - $173.08 monthly
- ☐ SIMPLY BLUE 40-0 - 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

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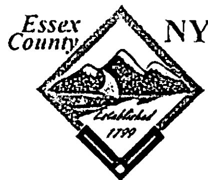

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CHOICE OF HEALTH INSURANCE COVERAGE FOR 2022

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

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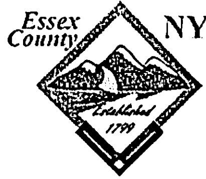

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2022 PREMIUM ENHANCEMENT PROGRAM
FULL-TIME BENEFIT EMPLOYEES

☐ I elect NOT to participate in the Premium Enhancement Programs for the Year 2022.

☐ 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, 2021 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, 2021 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 2022 Longevity Payment toward my share of the Health Insurance premiums on a monthly basis.

_________ 2022 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 2021 Time Sheet must be submitted with this form. *****

____

Print Name **Date**

____

Employee Signature

Personnel Office Use Only	☐ Approved by __________

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 ☐ Change in Status ____________
☐ New Hire ☐ Unpaid Leave of Absence
☐ Termination (Complete COBRA Form) ☐ 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**	**01/01/2022- 12/31/2022**	___-__-____

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				

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.

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PO Box 15136
Albany, NY 12212-5136
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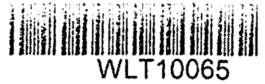
FSA Enrollment Form



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 #	Employer Group Name	Plan Year	Social Security Number
10065	Essex County	01/01/2022- 12/31/2022	- -

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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