Northwest Community Action Partnership (NCAP)
2018 Benefit Enrollment Form

Name: _____ $450 - Monthly Benefit Dollars

Group Health Insurance- Blue Cross Blue Shield

Northwest Community Action Partnership provides a health insurance plan which meets the minimum essential benefit requirement and the affordability requirement of the Affordable Care Act. The affordability requirement is being met by providing benefit dollars and a health insurance subsidy, if applicable, to help cover premium costs. Employees have a choice to use benefit dollars for health insurance or the other benefit options listed below.

I choose to enroll in the following health insurance plan: (Rates may change)
(If participating in Group Health Plan fill out the Nebraska Uniform Group Health Application)

_____**#39:** (Monthly rates)	_____**#54** (Monthly rates)	_____**#42** (Monthly rates)
_____ Employee - $792.72	_____ Employee - $630.02	_____ Employee - $704.71
_____ EE/Child(ren) - $1277.00	_____ EE/Child(ren) - $1102.54	_____ EE/Child(ren) - $1233.22

_____ **Coverage in the health plan is declined because:**
_____ I currently have other health coverage through:

_____ Spouse	_____ COBRA	_____ State Continuation
_____ Medicare	_____ Medicaid	_____ SCHIP
_____ Other insurance company		

Other reason(s) _____

To Be Completed by Employee	
Monthly Employer Benefit Dollar Contribution	**Monthly Employee Contribution**
$450.00	

*All employees who elect group health, dental insurance or vision insurance have the option to enroll in the Section 125/Cafeteria Plan which makes all group health, dental and vision insurance premiums pre-tax.

Group Dental Insurance- Dental By Design

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(If participating fill out the Companion Life Group Insurance Enrollment form)

_____ I choose to enroll in the following Dental Insurance Plan: Dental By Design: (Monthly Rates)

_____ Employee - $38.82
_____ Employee + Spouse - $73.80
_____ Employee + Child(ren) - $73.80
_____ Employee + Family - $120.33

_____ Coverage in the dental plan is declined.

To Be Completed by Employee	
Monthly Employer Benefit Dollar Contribution	**Monthly Employee Contribution**

*All employees who elect group health, dental insurance or vision insurance have the option to enroll in the Section 125/Cafeteria Plan which makes all group health, dental and vision insurance premiums pre-tax.

Group Vision Insurance – Vision By Design

(If participating fill out the Companion Life Group Insurance Enrollment form)

_____ I choose to enroll in the following Vision Insurance Plan: Vision By Design (Monthly Rates)

_____ Vision Essentials Option – Exam Only

_____ Employee Only- $1.27
_____ Employee plus one - $2.33
_____ Employee plus two - $2.73
_____ Family - $3.59

_____ Vision Select Option – Exam and Eyewear

_____ Employee Only - $9.34
_____ Employee plus one - $17.64
_____ Employee plus two - $20.88
_____ Family - $27.79

_____ Coverage in the Vison Plan is declined.

To Be Completed by Employee	
Monthly Employer Benefit Dollar Contribution	**Monthly Employee Contribution**

*All employees who elect group health, dental insurance or vision insurance have the option to enroll in the Section 125/Cafeteria Plan which makes all group health, dental and vision insurance premiums pre-tax.

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Voluntary Group Term Life Insurance – Companion Life Insurance Company

_____ I would like to participate in Term Life Insurance. (Monthly Rates)
(If participating fill out the Companion Life Group Insurance Enrollment form)
Employee Benefit Amount - _____ **Premium amount- _____**
Spouse Benefit Amount - _____ **Premium amount- _____**
(Not to exceed 50% of the employee's coverage maximum amount up to $25, 000)

Child(ren) Benefit Amount - _____ **Premium amount - _____**

_____ I choose not to participate in Term Life Insurance.

Voluntary Group Term Life Insurance – Companion Life Insurance Company

To Be Completed by Employee	
Monthly Employer Benefit Dollar Contribution	**Monthly Employee Contribution**

Voluntary Short Term Disability – Companion Life Insurance Company

_____ I would like to participate in Short Term Disability Insurance.

(If participating fill out the Companion Life Group Insurance Enrollment form)

To Figure Short Term Disability Premium

0	Gross Per Week
0.00	.60
0.00	.1
0.00	.46
0.00	Monthly Premium
0.00	Biweekly Premium

Monthly Employer Benefit Dollar Contribution	Monthly Employee Contribution

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Retirement Option – American Funds

_____ I would like to participate in the Retirement Option. **Monthly Amount: _____**

_____ I choose not to participate in the Retirement Option.

Totals

To Be Completed by Employee	
Monthly Employer Benefit Dollar Contribution	**Monthly Employee Contribution**

I authorize Northwest Community Action Partnership to deduct the appropriate bi-weekly employee contribution from my compensation.

After enrollment paperwork has been submitted by the employee and processed by the fiscal office all employees will receive the dollar amount that will be deducted from your paycheck bi-weekly.

Signature **Print Name** **Date**

HR Review:_____

Fiscal Review:_____

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