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| Welcome To Charleston, West VirginiaBroker LogoFSA/DCFSA/HSA/Dental/Vision Enrollment Form  **I Enrolled Online** |
| **Employee Name**   |  | | --- | |  | |
| **Last four of Employee Social Security Number**   |  |  | | --- | --- | |  |  |   **Employee Address Employee Phone Number**   |  |  | | --- | --- | |  |  |   **Complete this section ONLY if you elected PPB Plan C**  If you have elected PPB Plan C you may have an annual election of up to **$3,550** (single) and **$7,100** (family) deducted from your paycheck pretax\* and deposited directly in your HSA. Please complete below if you are electing this option. Amount may be less if not participating for a full 12 months.  **Single Coverage HSA Annual Election** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cannot exceed **$2,150**, the City is contributing $1,400)  **Family Coverage HSA Annual Election** $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cannot exceed **$4,300**, the City is contributing $2,800)  **$** [Annual Election Amount] **÷ 24** Paychecks **= $** Amount Per Paycheck that will be deducted.  I understand this election coverage is effective July 1, 2020 through June 31, 2021.  **Complete this section if you elected a plan OTHER THAN PPB Plan C & wish enroll in the FSA**  If you have elected the FSA (not available if you elected PPB Plan C) you may have an annual election of up to **$2,750** deducted from your paycheck pretax and deposited directly in your FSA. Please complete below if you are electing this option.  **Annual FSA Election $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  I understand this election coverage is effective July 1, 2020 through June 31, 2021.  **$** [Annual Election Amount] **÷ 24** Paychecks **= $** Amount Per Paycheck that will be deducted. |
| **Complete this section if you elect a Dependent Care FSA**  If you elected Dependent Care FSA, the maximum annual contribution is **$5,000** if you are single or if you are married and filing a joint income tax return; the limit is **$2,500 per parent** if you are married and filing a separate income tax return.  **Annual DFSA Election $ \_\_\_\_\_\_\_\_\_\_**  I understand this election coverage is effective July 1, 2020 - June 31, 2021.  **$** [Annual Election Amount] **÷ 24** Paychecks **= $** Amount Per Paycheck that will be deducted.  **Dental/Vision Election:** I choose the following coverage type and premium deduction:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Coverage Type** | **Standard Dental/Vision Election Per Pay** | | **Enhance Dental/Vision Election Per Pay** | | | Employee Only |  | $3.40 |  | $6.75 | | Employee + Spouse |  | $7.71 |  | $16.08 | | Employee + Children |  | $7.71 |  | $16.08 | | Family |  | $7.71 |  | $16.08 | | Waive Coverage |  |  |  |  |   Employee Signature Date   |  |  | | --- | --- | |  |  |   Signature above gives authorization to have all health/dental/vision elections deductions on a pre-tax basis.  **Return to the City via email: April.Thompson@cityofcharleston.org or fax 304-348-8055.** |