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| Welcome To Charleston, West VirginiaBroker LogoFSA/DCFSA/HSA/Dental/Vision Enrollment Form**I Enrolled Online** |
| **Employee Name**

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| **Last four of Employee Social Security Number**

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**Employee Address Employee Phone Number**

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**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:

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| **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

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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.** |