TOPEKA & SHAWNEE COUNTY PUBLIC LIBRARY

Topeka & Shawnee County Public Library

2022 Enrollment Form

Effective Date: January 1, 2022 (**Rates Effective**: December 1, 2021)

____
Name (print)

____
Phone

Election

☐ I do not want to make any changes to my health, dental, or vision insurance for 2022

☐ I want to make changes (add/drop) for: ☐ Medical, ☐ Dental, ☐ Vision, or ☐ Dependents. (Fill out second page)

HSA & FSA Accounts

Health Savings Account* *For those with HDHP coverage plan*	$ ______ per paycheck x 24 = $________ annual election
Flex Spending Account* - Medical	$ ______ per paycheck x 24 = $________ annual election
Flex Spending Account* - Dependent Care	$ ______ per paycheck x 24 = $________ annual election

*Additional form is required.

Waiver of Enrollment

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 63 days after your other coverage ends. If you have a new dependent as a result of marriage, birth, adoption, or placement adoption, you may be able to enroll yourself or your dependent in this plan, provided that you request enrollment within 63 days after the marriage, birth, adoption, or placement for adoption.

☐ I do not desire to enroll in Blue Cross & Blue Shield of Kansas coverage at this time and have no other insurance.

The group insurance program has been offered to me, and I am waiving my right to participate because:

☐ I am covered by: ____ my own, ____ my spouse's or, ____ parent's insurance program.

________________________ ________________________________ __________________________________
Spouse or Parent's Name Place of Employment Name of Insurance Company

☐ Other (Medicaid, Tri-Care, Medicare): ____________________________

Signature

____ _______________________________
Employee Signature Date

Fill out this side only if enrolling or making changes to coverages

Full Time Coverage Selections Rates shown are per paycheck (24). (See benefit overview for monthly rates.)

Coverage Type	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Decline
Medical: BCBSKS Option A: $3,000/$6,000 Deductible HDHP	☐ $36.59	☐ $104.71	☐ $74.07	☐ $140.83	☐
Medical: BCBSKS Option B: $1,000/$2,000 Deductible PPO	☐ $70.04	☐ $176.16	☐ $140.31	☐ $248.82	☐
Voluntary Dental: Delta Dental of KS	☐ $4.14	☐ $8.22	☐ $8.25	☐ $13.99	☐
Voluntary Vision: EyeMed	☐ $3.10	☐ $5.90	☐ $6.21	☐ $9.13	☐

Part Time Coverage Selections Rates shown are per paycheck (24). (See benefit overview for monthly rates.)

Coverage Type	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Decline
Medical: BCBSKS Option A: $3,000/$6,000 Deductible HDHP	☐ $184.67	☐ $409.77	☐ $373.85	☐ $598.32	☐
Medical: BCBSKS Option B: $1,000/$2,000 Deductible PPO	☐ $219.32	☐ $484.02	☐ $443.32	☐ $709.23	☐
Voluntary Dental: Delta Dental of KS	☐ $13.10	☐ $25.96	☐ $26.09	☐ $44.18	☐
Voluntary Vision: EyeMed	☐ $3.10	☐ $5.90	☐ $6.21	☐ $9.13	☐

Dependent Information Complete this section if you are adding your spouse or dependents in medical, dental, or vision coverage

	Add or Drop?	Name (First M Last)	Gender	SSN	Date of Birth
Spouse					
Child					
Child					
Child					
Child					

Coordination of Benefits

Will you or any enrolling dependents have other health coverage **in addition** to this plan? ☐ Yes ☐ No

____ ________________ ____________________

Insurance Company Name Group # ID#

____

Names of those who will be covered on other plan

Be sure to fill out and sign the front page.