2022-2023 Benefit Election Form

Employee Name: _____ **Date of Birth:** _____ **Phone:** _____

Social Security Number: _____ **Address:** _____

Health (Wellness/Non-Wellness) Monthly	
Option 1 $1,000	**Option 2 $2,000**
☐ Single: $75.23 /$167.18	☐ Single: $53.95 / $154.14
☐ Employee/Spouse: $154.22 / $342.72	☐ Employee/Spouse: $110.60 / $315.99
☐ Employee/Child(ren): $142.19 / $315.97	☐ Employee/Child(ren): $101.96 / $291.33
☐ Family: $230.96 (capped at $200)/ $513.24	☐ Family: $165.62 / $473.21
☐ **Waive coverage**	☐ **Waive coverage**

Dental Monthly	Vision Monthly
☐ Single: $2.92	☐ Single: $0.68
☐ Employee/Spouse: $5.47	☐ Employee/Spouse: $1.19
☐ Employee/Child(ren): $6.66	☐ Employee/Child(ren): $1.47
☐ Family: $10.73	☐ Family: $1.78
☐ **Waive coverage**	☐ **Waive coverage**

Dependent information only needs completed if you are adding coverage for spouse and/or children

	Dependent Information				
	Coverage Elected	Name: (Last, First, M.I.)	Date of Birth: (M/D/Year)	Sex: (M/F)	Social Security Number:
Spouse	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female	
Child	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female	
Child	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female	
Child	☐ Medical ☐ Dental ☐ Vision			☐ Male ☐ Female	

Are any of your dependents Social Security disabled? _____ Yes _____ No
Are you or any of your dependents enrolled in Medicare? _____ Yes _____ No

If Yes, Name(s) _____ **Medicare ID #** _____

Will you, your spouse , or your dependents keep other health coverage in addition to the health coverage offered through The Madison County? _____ **Yes** _____ **No**
If yes, please complete the following: Policy holder Name (First, Last): _____

Please list those covered by other health plan(s):_____

Policy No.: _____ **Effective Date:** _____

Employer Name (if provided through employer): _____

Insurance Company Name: _____ **Address:** _____

2022-2023 Benefit Election Form Continued-
Flexible Spending Accounts

Flexible Spending Accounts

The Madison County also offers you the opportunity to elect **Flexible Spending Accounts** or FSAs. These accounts are similar to the Health Savings Account in that you use pre-tax money to pay for eligible medical, dental and vision expenses. The difference is that with Flexible Spending Accounts, you have to use all of the funds in your account by the end of the plan year, or you will lose those funds. Madison County does not contribute to the FSA.

1. **Health Care FSA:** Use pre-tax money for eligible medical, dental and vision expenses. **Please note:** If you already have Health Savings Account (I), you cannot enroll in a Health Care FSA.

   2022-2023 Contribution Limit: $2,850

   Annual Election $_____
   ☐ I would like to elect the Health Care FSA for the 2022-2023 year.
   ☐ Decline

2. **Dependent Care FSA:** Use pre-tax money for eligible dependent care expenses.

   2022-2023 Contribution Limit: $2,500 if single or married and filing separately; $5,000 married and filing jointly

   Annual Election $_____
   ☐ I would like to elect the Dependent Care FSA for the 2022-2023 year.

Flex elections will be taken per pay period starting on the first payroll in March 2022.

2022-2023 Benefit Election Form Continued-Life and AD&D

Instructions: You will automatically be enrolled in the Basic Life and AD&D coverage. **If you currently have Voluntary Life your current elections will rollover to the new plan year. If you are enrolling for the first time or you are electing to increase your voluntary life insurance you will need to complete health questions and are subject to underwriting approval.** Please fill in the applicable information below for your Primary Beneficiary(ies) in Table 1 and for your Secondary Beneficiary(ies) in Table 2. **The percentage share of the proceeds must add up to 100%.**

Life and AD&D	Voluntary Life and AD&D
Employee Benefit: $20,000 **Spouse Benefit:** $2,000 ☐ Check this box if you have an eligible spouse **Child Benefit:** $2,000 ☐ Check this box if you have eligible children **Madison County pays 100% of the cost of coverage.**	**Benefit** ➢ **Employee:** Elect in increments of $10,000 to the lesser of 5X salary or $250,000. ➢ **Spouse:** Elect in increments of $5,000 to a maximum of $250,000. ➢ **Child:** $10,000. ☐ **Elect** Employee Amount $_____ Spouse Amount $_____ Child Amount $_____ ☐ **Waive coverage**

Please fill in the applicable information below for your Primary Beneficiary(ies) in Table 1 and for your Secondary Beneficiary(ies) in Table 2. **The percentage share of the proceeds must add up to 100%.**

Table 1: Primary Beneficiary(ies)				
Name: (Last, First, M.I.)	**Relationship to Employee:**	**Social Security Number:**	**% Share of Proceeds:**	**Date of Birth:**
Address:	**Phone Number:**			
Name: (Last, First, M.I.)	**Relationship to Employee:**	**Social Security Number:**	**% Share of Proceeds:**	**Date of Birth:**
Address:	**Phone Number:**			

Table 2: Secondary Beneficiary(ies)				
Name: (Last, First, M.I.)	**Relationship to Employee:**	**Social Security Number:**	**% Share of Proceeds:**	**Date of Birth:**
Address:	**Phone Number:**			
Name: (Last, First, M.I.)	**Relationship to Employee:**	**Social Security Number:**	**% Share of Proceeds:**	**Date of Birth:**
Address:	**Phone Number:**			

2022-2023 Benefit Election Form Continued-Disability

Instructions: You will automatically be enrolled in the Short-Term and Long-Term Disability plans and Madison County will pay the premiums for both plans.

Short Term Disability	Long Term Disability
Benefit ➢ 66 2/3% of your weekly earnings up to a maximum of $1,000. ➢ Benefits begin on the 15th day for illness or injury ➢ Benefits continue for 11 weeks.	**Benefit** ➢ Benefits begin after you've been disabled for 90 days. ➢ Monthly benefit is 66 2/3% of your salary up to a maximum of $5,000. ➢ Benefits continue until Social Security Normal Retirement Age.

2022-2023 Benefit Election Form Continued- Accident and Critical Illness/Hospital Plans

Voluntary Accident – Rates are per pay period	
Option 1	**Option 2**
☐ Single: $4.75	☐ Single: $6.30
☐ Employee/Spouse: $7.95	☐ Employee/Spouse: $10.58
☐ Employee/Child(ren): $9.12	☐ Employee/Child(ren): $12.22
☐ Family: $12.95	☐ Family: $17.36
☐ **Waive coverage**	☐ **Waive Coverage**

Voluntary Critical Illness/Hospital Indemnity – Rates are per pay period	
Option 1	**Option 2**
☐ Single: $9.24	☐ Single: $15.57
☐ Employee/Spouse: $16.76	☐ Employee/Spouse: $27.44
☐ Employee/Child(ren): $11.76	☐ Employee/Child(ren): $19.39
☐ Family: $20.01	☐ Family: $32.37
☐ **Waive coverage**	☐ **Waive Coverage**

Dependent information only needs completed if you are <u>adding</u> coverage for spouse and/or children

	Dependent Information for Accident, Critical Illness, Hospital Indemnity			
	Coverage Elected	Name: (Last, First, M.I.)	Date of Birth: (M/D/Year)	Sex: (M/F)
Spouse	☐ Accident ☐ Critical Illness/Hospital Indemnity			☐ Male ☐ Female
Child	☐ Accident ☐ Critical Illness/Hospital Indemnity			☐ Male ☐ Female
Child	☐ Accident ☐ Critical Illness/Hospital Indemnity			☐ Male ☐ Female
Child	☐ Accident ☐ Critical Illness/ Hospital Indemnity			☐ Male ☐ Female

OVER – Please sign and date on the next page.

Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this enrollment form.
I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by
Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc.
(each referenced herein as "Wellmark"). I authorize my employer, as my agent, to deduct from my pay or collect
from me in advance the monthly rates therefore and remit such sums to Wellmark on my behalf. This authorization is
to remain in effect until Wellmark is notified by me or my employer to the contrary. I understand that written notice
of rate changes will be furnished to my employer as my agent. I further understand that the coverages applied for
will not start until after this application and the appropriate coverage rates are received and accepted by Wellmark and
an effective date of coverage is established by Wellmark. I certify that, after this enrollment form was completed, I
carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been
knowingly withheld. I understand that Wellmark will rely on the completeness and truthfulness of the information given
and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose
or concealed any material fact, Wellmark will be entitled to declare the contracts applied for void and to refuse allowance
on benefits to any person thereunder. I understand and grant authorization for my employer, group sponsor, consultant,
or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment
purposes. I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers

In order for Wellmark to report my coverage status to the federal government, I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all
members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security
number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security
or tax identification numbers, I understand Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided Social Security numbers or tax identification numbers to
Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on
my ID card. If I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a **$50 penalty per violation** imposed by the Internal Revenue Service.

Over - Signe and date the next page

Release of Medical Information

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to Wellmark all health and mental health records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that Wellmark or the Provider have relied on it in the use or disclosure of protected health information. This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of all information received and it will not be released to any person or facility. The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to
condition eligibility determination and enrollment on the receipt of this signed authorization.

Signature_____ Date _____

2022 Madison County Wellness Visit Confirmation Form

(Please complete a separate form for each member receiving a wellness visit)

As part of the Madison County Wellness Program, employees and their spouses who meet program participation guidelines will be eligible for a premium discount for 7/1/2022-7/1/2023

Take this form with you to your scheduled annual wellness visit to be completed and signed by your doctor.

The visit needs to have been completed between the dates of **7/1/20221-7/1/2022**. New hires will have 2 months to provide a completed form by their doctor to be eligible for the premium discount, until form is received new hires will be charge non-wellness rate. New hire will be reimbursed overage payment if/once Wellness form is received.

It is the participant's responsibility to submit the Wellness Visit Confirmation Form to Madison County Human Resources by 7/1/2022 to qualify for the premium discount.

PATIENT'S information (to be completed by patient):

Patient's Name: _____ Male □ Female □ DOB: _____

Patient's Address: _____

Patient's Phone Number: _____ Relationship: Employee □ Spouse □

I authorize the physician's office completing this form to release the information below to my Human Resources department.

Patient's Signature: _____

DOCTOR'S information (to be completed by doctor):

Date of Wellness Visit: _____

- **Preventative Exam completed**
  - **□ Yes □ No**
- **Annual screening (blood pressure, BMI, etc.) completed, if appropriate**
  - **□ Yes □ No**
- **Comprehensive Metabolic Panel (CMP) completed, if appropriate**
  - **□ Yes □ No**

Note: Some testing and/or labs ordered during your wellness exam may be subject to a co-pay. If your doctor has a concern and orders diagnostic testing and/or labs during your exam you may be held financially responsible. Be sure to discuss with your doctor.

I hereby certify that the above information is correct.

Physician's Name: _____

Physician's Signature: _____ Date: _____

Office Phone Number: (_____) _____