WNY DISTRICT OF THE WESLEYAN CHURCH
INDEPENDENT HEALTH 2018 INSURANCE ELECTION / WAIVER

ALL EMPLOYEES MUST COMPLETE THIS FORM. NEW ENROLLEES (OR ANYONE CHANGING DEPENDENT STATUS/ADDRESS) MUST ALSO COMPLETE THE 2 PAGE INDEPENDENT HEALTH APPLICATION/CHANGE FORM.

Name:	**Home Ph:**
Address:	**Email:**
City: **State:** **Zip:**	
Plan Year: January 1, 2018 to December 31, 2018	**Benefit Effective Date: 1/1/2018**

I elect the following INDEPENDENT HEALTH i DIRECT 1 SILVER COINSURANCE HSAQ HDHP medical insurance plan (#22997) option for 2018: (Must check one)

Employee	☐ $0.00/cost
Employee & Spouse	☐ $0.00/cost
Employee & Child(ren)	☐ $0.00/cost
Family	☐ $0.00/cost
Pediatric Dental (for children under age 19)	☐ $15.43/child/month
I DECLINE THIS HEALTH COVERAGE:	☐

I understand that if I have a Health Savings Account (HSA) in connection with my HDHP medical insurance, the maximum amount that can be contributed to the HSA is:

Health Savings Account Maximum Contributions for the 2018 Tax Year	
Maximum Single HSA Contribution:	$3,450 for 2018
Maximum Family HSA Contribution:	$6,900 for 2018
Maximum HSA Catch-Up Contribution:	$1,000 for 2018 (over age 55)

BENEFIT PLAN TERMS

- If applicable, I agree that my compensation will be reduced by the Wesleyan Church by the amount of my required contributions (communicated to me under separate cover) for the benefit plan option of my choice.
- I acknowledge that I have received the medical insurance Benefit Summary plan and the Summary of Benefits of Coverage (SBC) for my specific plan choice.
- I understand that if I am enrolling for the first time, changing my dependent status or personal information (name change, address change, etc.), in addition to this form, I must also complete an Independent Health Application Form and turn it in to the WNY District of the Wesleyan Church by the Open Enrollment deadline in order to be enrolled in my plan of choice for the 2018 plan year.
- If I am electing to DECLINE health coverage for 2018, I am waiving my right to company sponsored medical coverage for the Plan Year. I will NOT be eligible to elect health benefits until the following plan year, UNLESS I experience a qualifying change in status (see below).
- I cannot change or revoke my plan election at any time during the Plan Year unless I experience a **Change in Status**. Changes in status include but are not limited to: marriage, divorce, legal separation, annulment; death of a spouse or child; birth or adoption of a child; termination or commencement of employment of a spouse; you or your spouse's employment status changes from full-time to part-time or vice versa; or you or your spouse take an unpaid leave of absence. Any change in benefit elections resulting from a change in status must correspond, be consistent and on account of the event. If you experience a change in status ***and*** wish to change your benefit elections it is your responsibility to notify the Benefits Administrator within 30 days of the date of the event.
- Prior to the first day of each Plan Year I will be offered the opportunity to change my health insurance benefit elections for the following plan year. If I do not complete a new election form at that time, I will be treated as having elected to continue my insured benefit elections then in effect for the new Plan Year.

Employee Authorization:_____ **Date:**_____