WNY DISTRICT OF THE WESLEYAN CHURCH
INDEPENDENT HEALTH 2024 INSURANCE ELECTION / WAIVER

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

Name:	**Home Ph:**
Address:	**Email:**
City: **State:** **Zip:**	
Plan Year: January 1, 2024 to December 31, 2024	**Benefit Effective Date: 1/1/2024**

This enrollment/waiver form is relative to the following WNY District of the Wesleyan Church subgroup:

- Sub grp 01 Big Tree Wesleyan
- Sub grp 02 Christ Chapel Wesleyan
- Sub grp 03 East Aurora Wesleyan
- Sub grp 04 Fellowship Wesleyan Church
- Sub grp 05 Fillmore Wesleyan Church
- Sub grp 06 Hess Road Wesleyan Church
- Sub grp 08 Houghton Wesleyan
- Sub grp 09 North Collins Wesleyan Church
- Sub grp 10 North Park Wesleyan
- Sub grp 11 The Vine Wesleyan
- Sub grp 12 Valley Wesleyan Church
- Sub grp 13 Wesleyan Church of Orchard Park
- Sub grp 14 WNY District of Wesleyan Church

I elect the following INDEPENDENT HEALTH medical insurance plan option for 2024: (Must check one)

I Direct Silver Copay Option 2 PLAN:

Employee	☐ $ /cost (see page 2)
Employee & Spouse	☐ $ /cost (see page 2)
Employee & Child(ren)	☐ $ /cost (see page 2)
Family	☐ $ /cost (see page 2)
Pediatric Dental (for children under age 19)	☐ $16.77/child/month
I DECLINE THIS HEALTH COVERAGE:	☐

i DIRECT 1 SILVER COINSURANCE HSAQ HDHP – HSA Eligible Plan

Employee	☐ $ /cost (see page 2)
Employee & Spouse	☐ $ /cost (see page 2)
Employee & Child(ren)	☐ $ /cost (see page 2)
Family	☐ $ /cost (see page 2)
Pediatric Dental (for children under age 19)	☐ $16.77/child/month
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Pediatric Dental (for children under age 19)	☐ $16.77/child/month
I DECLINE THIS HEALTH COVERAGE:	☐

Please see page 2/2 for Important Plan Benefit Terms and mandatory signature ->

I understand that if I have a Health Savings Account (HSA) in connection with my HDHP medical plan the maximum amount that can be contributed to the HSA in 2024 is:

Health Savings Account Maximum Contributions for the 2024 Tax Year	
Maximum Single HSA Contribution:	$4,150 for 2024
Maximum Family HSA Contribution:	$8,300 for 2024
Maximum HSA Catch-Up Contribution:	$1,000 for 2043 (over age 55)

**Note –*
If enrolling in the iDirect Silver Copay Option 2 plan you are NOT able to contribute to a Health Savings Account/HSA.

BENEFIT PLAN TERMS

- If applicable, I agree that my compensation will be reduced by the WNY District of the Wesleyan Church "sub group", under which I am employed, by the amount of my required contributions for the benefit plan option of my choice. **I understand that I must contact the supervisor of my church for information on the church's premium contribution and what my cost of insurance will be. The corresponding cost of insurance amount must be inserted into this document according to the plan and tier I have selected.**

- If I am electing pediatric dental for my dependents under the age of 19 years, I understand that the cost is a per/child/month charge.

- 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 2024 plan year.

- If I am electing to DECLINE health coverage for 2024, 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:**_____