CITY OF KINSTON

PREMIUM CONVERSION BENEFIT PLAN ELECTION FORM

PLAN YEAR: JULY 1, 2016 THROUGH JUNE 30, 2017

NAME: _____ DATE: _____

EMPLOYEE ADDRESS: _____CITY:_____ ZIP:_____

Election for Benefits

As an eligible employee of the City of Kinston, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as other rights and obligations which I have under the plan.

In accordance with my rights under the Plan, I elect to participate in the Premium Conversion Benefit Plan and to have dependent coverage under the City's Health Care Benefit Plan. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the plan year as remains after the date of the agreement.) **Employees Initials: _____**

Health Care Options

Medical Coverage through Blue Cross Blue Shield (**Initial Desired Coverage**)

Traditional Plan (PPO)

Int. _____	Employee Only (*)	$32.50	
Int. _____	Employee/Child(ren)	$362.98	
Int. _____	Employee/Spouse	$390.93	
Int. _____	Employee/Family	$672.67	

High Deductible Plan (HSA)

Int. _____	Employee Only (*)	$32.50	Add. Amt. _____ Initial _____
Int. _____	Employee/Child(ren)	$202.83	Add. Amt. _____ Initial _____
Int. _____	Employee/Spouse	$289.16	Add. Amt. _____ Initial _____
Int. _____	Employee/Family	$526.99	Add. Amt. _____ Initial _____

(*) No Increase

_____ PLEASE CHECK HERE IF MAKING **ANY** CHANGE FROM CURRENT COVERAGE

Dental Care

* No Increase *

Dental Coverage through Met Life (Initial desired coverage)

Int. _____	Employee Only	$13.63
Int. _____	Employee/+1 Dependent	$27.48
Int. _____	Employee/+2 or More Dependents	$49.45

Vision Care

Vision Coverage through MetLife (Initial desired coverage)

			High 1	Low 2
Int. _____	Employee Only	(check one)	☐ $5.39	☐ $3.50
Int. _____	Employee/Child(ren)	(check one)	☐ $10.16	☐ $6.75
Int. _____	Employee/Spouse	(check one)	☐ $10.16	☐ $6.75
Int. _____	Employee/Family	(check one)	☐ $16.05	☐ $10.47

Dependents:

Name	Address(if different)	Birthdate	Med.	Dental	Vision	Dep. Life
Spouse			(Y/N)	(Y/N)	(Y/N)	(Y/N)
Child			(Y/N)	(Y/N)	(Y/N)	(Y/N)
Child			(Y/N)	(Y/N)	(Y/N)	(Y/N)
Child			(Y/N)	(Y/N)	(Y/N)	(Y/N)
Child			(Y/N)	(Y/N)	(Y/N)	(Y/N)
Child			(Y/N)	(Y/N)	(Y/N)	(Y/N)

Employee Signature: _____Date: _____