2024-2025 BENEFITS ELECTION/WAIVER FORM

PATHWAYS Moving Care Forward

Last Name (Please Print)	First Name	Employee ID Number	Effective Date

I am not making any changes to any plan(s) for the 2024-2025 year____ (rates/payroll deductions, I approve new rates)

MEDICAL COVERAGE - CONTRIBUTIONS ARE DEDUCTED EACH PAYCHECK

WAIVING MEDICAL_____ PROOF OF COVERAGE____ Opt Out Credit $100 per month_____

KAISER – HMO (Traditional)	Check One	Full Time Cost	Part Time Cost	*Domestic Par – Post Tax
Employee Only		0	$229.26	
Employee & One Dependent*		$458.51	$687.77	
Employee with 2 or more Dependents*		$839.07	$1,068.33	

KAISER – HMO (Deductible)	Check One	Full Time Cost	Part Time Cost	*Domestic Par- Post Tax
Employee Only		0	$200.13	
Employee & One Dependent*		$400.25	$600.37	
Employee with 2 or more Dependents*		$732.45	$932.58	

DENTAL COVERAGE – CONTRIBUTIONS ARE DEDUCTED EACH PAYCHECK

WAIVING DENTAL_____

SunLife DHMO	Check One	Full Time Cost	Part Time Cost	*Domestic Par – Post Tax
Employee Only		0	$3.10	
Employee & One Dependent*		$5.00	$8.10	
Employee with 2 or more Dependents*		$11.72	$14.82	

SunLife DPPO	Check One	Full Time Cost	Part Time Cost	*Domestic Par – Post Tax
Employee Only		0	$11.37	
Employee & One Dependent*		$22.51	$33.88	
Employee with 2 or more Dependents*		$60.09	$71.46	

VISION COVERAGE – CONTRIBUTIONS ARE DEDUCTED EACH PAYCHECK

WAIVING VISION____

VSP (Vision Services Plan)	Check One		Full and Part Time Cost	*Domestic Par – Post Tax
Employee Only			$6.47	
Employee & One Dependent*			$10.05	
Employee with 2 or more Dependents*			$15.94	

FLEXIBLE SPENDING ACCOUNTS (FSA, Section 125) you must also complete an FSA Form

Health Care Annual Contributions	$	Maximum of $2,000 Annual Goal
Dependent Care Annual Contributions	$	Maximum of $5,000 Annual Goal
Transit and/or Parking Monthly Contributions	$	Max $315 Transit / Max $315 Parking (monthly)

I authorize Pathways Home Health and Hospice to deduct from my earnings, the required contributions. I have carefully read this form prior to completion. I am responsible for the accuracy of this form. I will verify my paystub to assure the accuracy of my elections.

Employee Signature: _____ **Date:** _____