RETURN THIS FORM **AND** YOUR 2018 OPEN ENROLLMENT APPLICATION TO HUMAN RESOURCES

Oregon Conference of Seventh-day Adventists

HEALTH CARE ASSISTANCE PLAN (HCAP) Election and Verification Form

Name _____
(Please Print)

Please select a level of coverage and whether you wish to pay the premium for that coverage on a pre-tax or after tax basis.

☐ Pre-tax	☐ After-tax	Employee Only Coverage	$81 per month
☐ Pre-tax	☐ After-tax	Employee + 1 Child	$106 per month
☐ Pre-tax	☐ After-tax	Employee + Children	$130 per month
☐ Pre-tax	☐ After-tax	Employee + Spouse	$167 per month ($539/mo if spouse earns $35,463 or more a year)
☐ Pre-tax	☐ After-tax	Family	$207 per month ($592/mo if spouse earns $35,463 or more a year)

☐ Check here if you have joint dependent custody and your dependents have other insurance through another legal guardian. You will need to contact the Human Resources department to coordinate care according to any court order and the HCAP rules.

If you have other group health insurance coverage and choose to opt out of this plan, please complete and return the enrollment form marking "Decline Coverage."

Spouse Employment Status
If covering a spouse, please select the correct situation for your spouse and provide the verifying documentation.

☐ My spouse is not employed (no paperwork necessary).

☐ My spouse also works for the Oregon Conference (no paperwork necessary).

☐ My spouse is employed and has a gross annual income above $35,463. **Please submit a copy of your spouse's 2017 W-2 form or Schedule C (or business profit estimate) by February 16, 2018 for verification. If verification is not provided by 2/16/18, we will set your payroll deduction at the higher amount.**

My compensation each pay period will be reduced by the amount necessary to purchase the benefits I have enrolled in. If the cost of this coverage increases or decreases during the Plan Year, the contribution amount will be adjusted to reflect such increase or decrease. I understand that my election will be ***effective January 1, 2018,*** or the first day of the month on which Health Care Assistance Plan coverage begins during the Plan Year, if later.

I understand that if I fail to enroll or re-enroll during any Open Enrollment Period for any subsequent Plan Year, I will be deemed to have made the same elections, if any, for coverage under the Health Care Assistance Plan and the same agreement to have compensation reduced for that Plan Year as indicated on the most recently submitted *HCAP Election and Verification Form*, including any changes in the cost of coverage under the Health Care Assistance Plan.

I may not change or revoke this *HCAP Election and Verification Form* as of any date prior to the beginning of the first day of the next Plan Year, unless I have a qualifying change in status (as defined by the Plan and the Internal Revenue Code) that is reported on a Plan form and approved by the Plan Administrator.

I understand that choosing to have my contributions deducted on a pre-tax basis will reduce my compensation for Social Security tax purposes and my Social Security benefits may be decreased, and that the Oregon Conference and the Plan Administrator have given no tax or legal advice to me and that I should consult my own tax and legal advisors in deciding upon spending account elections and the taxability of benefits received through the Health Care Assistance Plan.

Signature _____ **Date** _____

Have you completed and signed your Open Enrollment Application?