2023 Medical Enrollment Form:

Submit form via email at hr@picsmn.org, fax at 651-967-5061 or mail to:
Partners in Community Support – ATTN Mary Bibro
1605 Eustis St
St Paul, MN 55108

Medical Benefits Election From

Name:	Address:	Social Security Number: __ __ __ - __ __ - __ __ __ __
Date of Birth: __ __ / __ __ / __ __ __ __	Gender: ☐ Male ☐ Female	Email Address:

Medical Coverage Choices

Medical Coverage Waiver *(Failure to return form results in automatic waive of coverage)*

☐ I do not need coverage under PICS group plan

Medical Plan Coverage *Administered By:* UHC	PICS Monthly Subsidy	Employee Monthly Cost	Employee Cost Per Pay Period
☐ Employee Only	$814.46	$350.00	**$175.00**
☐ Employee + Spouse	$1,478.03	$1,083.76	**$541.88**
☐ Employee + Child(ren)	$1,463.73	$981.62	**$490.81**
☐ Employee + Family	$1,635.33	$2,207.38	**$1,103.69**

Optional: **Health Savings Account (HSA)** – *administered by* ***Further***

2023 IRS Annual Limits for HSA:

- The maximum contribution is $3,850 for Employee Only coverage
- The maximum contribution is $7,750 for FAMILY coverage.

*HSA catch-up contributions (age 55 or older): $1,000.00.

☐ I am electing to contribute $_____ per pay period.

Dependent Information *(Fill in the following information ONLY if dependents are to be covered – attached additional sheet if needed)*

Name: First, M.I., Last (John A. Doe)	Date Of Birth (M/D/Y)	Relationship	Gender	Social Security #:
Name:			☐ Male ☐ Female	__ __ __ - __ __ - __ __ __ __
Name:			☐ Male ☐ Female	__ __ __ - __ __ - __ __ __ __

I have received, read and understand the materials and disclaimers explaining the benefits program. I understand that by signing and submitting this form, I am making a binding election for the choices indicated above. This election is binding subject to my right to make changes according to the provisions of the program and subject to any changes required to comply with Federal Tax laws.

Employee Signature: _____ Date Signed: _____

PICS Office Use Only

Benefit Deduction Code: _____	Arrears Needed: Yes No	HSA Enrolled: Yes No
Benefit Start Date: ____/____/_____	EE Arrear Amount: $_____	HSA Bank Doc: Yes No
Pay Period Start Date: ____/____/_____	ER Arrear Amount: $_____	Emails Sent: _____ Payroll _____ Employee / Rep
GP Set Up Complete: _____ date: _____	Carrier Set Up Complete: _____ date: _____	