# 2026-2027 BENEFITS ENROLLMENT FORM

## A. EMPLOYEE INFORMATION (PLEASE PRINT)

| | | | | |
|---|---|---|---|---|
| Name (Last, First, MI) | | | Employee ID | Social Security Number |
| Street Address | | City | State | Zip |
| Email Address | | | Date of Hire | |
| Home Phone | Cell Phone | ☐ Male ☐ Female | ☐ Married ☐ Single | ☐ Divorced ☐ Separated | Date of Birth |
| Eligibility Date | | Enrollment Date | | |

**Below are your per pay contributions for the Medical, Dental and Vision Plan options and a section to choose FSA elections. FSA elections must reflect the per pay amount to be deducted and cannot exceed annual or monthly limits (Per Pay $$ X 26 = Annual Election).**

### B. MEDICAL PLAN OPTION

***Medical Coverage includes Prescription Drug Coverage***
***Please check (✓) one box***

| CIGNA PLAN | |
|---|---|
| **Employee Only** | ☐ $54.24 |
| **Employee + Spouse** | ☐ $249.54 |
| **Employee + Children** | ☐ $109.49 |
| **Family** | ☐ $295.90 |
| ☐ **WAIVE MEDICAL COVERAGE** | |

### C. DENTAL PLAN OPTION

***Please check (✓) one box***

| DPPO PLAN | |
|---|---|
| **Employee Only** | ☐ $4.07 |
| **Employee + Spouse** | ☐ $8.78 |
| **Employee + Children** | ☐ $8.78 |
| **Family** | ☐ $14.55 |
| ☐ **WAIVE DENTAL COVERAGE** | |

### D. VISION PLAN OPTION

***Please check (✓) one box***

| NVA PLAN | |
|---|---|
| **Employee Only** | ☐ $1.40 |
| **Employee + Spouse** | ☐ $2.79 |
| **Employee + Children** | ☐ $2.79 |
| **Family** | ☐ $4.10 |
| ☐ **WAIVE VISION COVERAGE** | |

### E. FLEXIBLE SPENDING ACCOUNTS (FSA) ELECTION

***Please check (✓) one box***

☐ I hereby elect **to participate** in the Flexible Spending Accounts

☐ I hereby elect **NOT to participate** in the Flexible Spending Accounts

**Healthcare FSA Election Amount (per pay):** $_____

**Dependent Care FSA Election Amount (per pay):** $_____

**Commuter Benefits Election Amount (per pay):** $_____

For the 7/1/2026 plan year, the monthly or annual maximums are as follows:

- Healthcare FSA: $3,400 annual limit
- Dependent Care FSA: $7,500 (or $3,750 if married and filing separate)
- Commuter Benefits: Up to $340/month for both Transportation and Parking

**F. DEPENDENT INFORMATION** *(Indicate dependents that you want covered by your medical, dental, or vision plans)*

| Name (Last, First, MI) | Gender | Date of Birth | Social Security Number | Coverage |
|---|---|---|---|---|
| Spouse/Partner | ☐ Male ☐ Female | | | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ Male ☐ Female | | | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ Male ☐ Female | | | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ Male ☐ Female | | | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ Male ☐ Female | | | ☐ Medical ☐ Dental ☐ Vision |

***If enrolling more than four children, please attach a separate sheet of paper with the above information.***

## CONFIRMATION OF ELECTIONS:

I apply for coverage, as indicated, for which I am or may become eligible through my employment with Abilities of Northwest Jersey Inc. I have read the above statements and represent they are true to the best of my knowledge. If applicable, the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I authorize my employer to deduct from my pay the necessary premiums (if any) to be withheld through payroll deduction and, where allowed, on a pre-tax basis, in equal installments throughout the plan year.

**Employee's Signature** **Date**

## WAIVER OF INSURANCE

I_____, hereby certify that the insurance plans offered by Abilities of Northwest Jersey Inc., have been explained and offered to me. However, by my own free will and without coercion, I have decided to waive my enrollment and refuse insurance coverage for myself and my eligible dependents. I further understand that should I want to enroll myself or my eligible dependents for medical and dental coverage in the future, I and/or my eligible dependents will be required to submit proof of coverage loss through another insurance carrier. If documentation is not submitted, enrollment requests will only be accepted during annual open enrollment each year.

**Employee's Signature** **Date**

**EMPLOYER VERIFICATION** *(To be completed by employer. Employer signature required)*

Signature Date

Effective Date