GPS SOLUTIONS

Payroll Deduction Form

Section 1: Employee Information: All Information is required							
Legal Last Name:	Legal First Name:	M.I.	Marital Status ☐S ☐M ☐D ☐W	Social Security Number*	Gender/Sex ☐M ☐F	Cell Phone Number	
Mailing Address	City	State	Zip	Email Address	Date of Birth	Effective Date:	Date of Hire:

Section 2: Dependent Information: List all family members to be covered. If you have more than four dependents, complete additional copies of this form

	Legal Last Name	Legal First Name	MI	Date of Birth	Gender/Sex	Non – US Resident	Social Security Number*	Relationship
Spouse					☐ M ☐ F			
Dep. 1					☐ M ☐ F			
Dep. 2					☐ M ☐ F			
Dep. 3					☐ M ☐ F			
Dep. 4					☐ M ☐ F			

*Social security number is required if not already on file with HR. Leave blank if it is on file.

If you are a new hire, or electing benefits for the first time, or making changes to your current medical dental, or vision benefits, you must complete the BCBS/BCN ECOS form, in addition to this form.

Section 3: Medical, Dental & Vision Election

MEDICAL	20 PAYROLL DEDUCTIONS	24 PAYROLL DEDUCTIONS	WAIVING COVERAGE
BLUE CROSS BLUE SHIELD PPO $1,000	☐ Single: $230.36 ☐ Double: $622.46 ☐ Family: $793.08	☐ Single: $191.97 ☐ Double: $518.72 ☐ Family: $660.90	☐
BLUE CARE NETWORK / HMO $1,000	☐ Single: $90.70 ☐ Double: $287.27 ☐ Family: $374.09	☐ Single: $75.58 ☐ Double: $239.39 ☐ Family: $311.74	☐
BLUE CARE NETWORK / HMO/HSA $1,500 ☐ **With HSA Account (you MUST fill in an annual election amount to the right)** ☐ **Without HSA Account**	☐ Single: $54.71 ☐ Double: $200.89 ☐ Family: $266.12	☐ Single: $45.59 ☐ Double: $167.41 ☐ Family: $221.77	☐
VOLUNTARY DENTAL	**20 PAYROLL DEDUCTIONS**	**24 PAYROLL DEDUCTIONS**	
Delta Dental New Carrier	☐ Single: $23.63 ☐ Double: $44.53 ☐ Family: $85.27	☐ Single: $19.69 ☐ Double: $37.11 ☐ Family: $71.06	☐
VOLUNTARY VISION	**20 PAYROLL DEDUCTIONS**	**24 PAYROLL DEDUCTIONS**	
Delta Dental New Carrier	☐ Single: $4.88 ☐ Double: $9.76 ☐ Family: $15.71	☐ Single: $4.07 ☐ Double: $8.13 ☐ Family: $13.10	☐

HSA 2023 Account: Annual election amount *(Required)*

I elect to have $_____ withheld annually, pre-taxed

Section 4: Employer Paid Benefits for Full-Time Employees: Life, AD&D and Long Term Disability

Life & AD&D	$25,000 for full-time eligible employees at no cost to employee.
Long Term Disability	Full-time eligible employees. 60% of pre-disability earnings up to a maximum of $6,000 per month; at no cost to employee.

Page 2 Continued: Employee Name:

Section 5: Voluntary Short Term Disability (Full-time eligible employee only)

This benefit covers you for up to 11 weeks during disability at 60% of your annual earnings	Enter your amount per pay here from worksheet below	☐ Yes, I wish to elect Vol. short term disability* ☐ No, I am declining to elect Vol. short term disability

Calculate your per pay withholding	SAMPLE: Using 24 pays	For you to use:
1.Enter Annual Gross Earning	$40,000	
2.Divide by 52	$40,000 ÷ 52 = $769.23	
3.Multiply by 60%	$769.23 X 60% = $461.54	
4.Amount from line 3 Divide by $10	$461.54 ÷ $10 = $46.15	
5. Amount from line 4 Multiple by your age rate from chart on the right	$46.15 X $0.980 = $45.23	
6. Amount from line 5 Multiply by 12	$45.22 X 12 = $542.77	
7. Amount from line 6 Divide by pay (20 or 24)	$542.77 ÷ 24 = $22.62 enter in Section 5 above	

Your Age as of 1/1/2023	Rate Per $10		Your Age as of 1/1/2023	Rate Per $10
Under 25	$0.430		50-54	$0.310
25-29	$1.200		55-59	$0.390
30-34	$1.490		60-64	$0.520
35-39	$0.980		65-69	$0.630
40-44	$0.370		70 +	$0.630
45-49	$0.250			

Section 6: Voluntary Term Life & AD&D (Full-time eligible employees and dependents)

Employee: Guarantee Issue up to $110,000. Max $500,000 or up to 5 times your earnings	Enter per pay amount and election amount from worksheet	☐ Yes, I wish to elect Vol. Life & AD&D Insurance* ☐ No, I am declining to elect Vol. Life & AD&D Insurance
Spouse: Guarantee Issue up to $15,000. Max $500,000 not to exceed 100% of employee amount	Enter per pay amount and election amount from worksheet	☐ Yes, I wish to elect Vol. Life & AD&D Insurance* ☐ No, I am declining to elect Vol. Life & AD&D Insurance
Dependent: Up to $10,000 in $2,000 increments	Enter per pay amount and election amount from worksheet	☐ Yes, I wish to elect Vol. Life & AD&D Insurance* ☐ No, I am declining to Vol Life & AD&D Insurance

Employee must purchase Vol. Term Life in order for spouse and/or dependent to elect coverage.

Your Age as of 1/1/2023	**Employee** Monthly Rate Per $10,000	**Spouse** Monthly Rate Per $5,000	**Child(ren)** Monthly Rate Per $2,000	Your Age as of 1/1/2023	**Employee** Monthly Rate Per $10,000	Spouse Monthly Rate Per $5,000
15-24	$0.760	$0.395	$0.938	50-54	$2.260	$1.145
25-29	$0.760	$0.395		55-59	$3.960	$1.995
30-34	$0.960	$0.495		60-64	$5.860	$2.945
35-39	$1.060	$0.545		65-69	$9.960	$4.995
40-44	$1.160	$0.595		70 -74	$14.160	$7.095
45-49	$1.560	$0.795		75+	$14.160	$7.095

Calculate your per pay withholding	SAMPLE: using 24 pay	For you to use:
1.Enter the amount of coverage	$40,000	
2. Divide by $10,000 for Employee, $5,000 for Spouse or $2,000 for Child(ren)	$40,000 ÷ $10,000 = 4	
3.Amount from line 2, Multiply by age rate above *(For spouse, use employee age)*	4 x $1.560 = $6.24	
4.Enter amount from line 3 Multiple by 12	$6.24 X 12 = $74.88	
5. Enter the amount from line 4 and divide by pay (20 or 24)	$74.88 ÷ 24 = $3.12 Per Pay	

**The employee understands and agrees that if the amount the employee calculates for Voluntary products differs from UNUM's calculations of the premium, the employee authorizes the payroll deduction based on UNUM's calculation.*

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Section 7: Declining ALL employee paid benefits

☐ By checking this box, I certify I have been provided the opportunity enroll in the employee cost shared benefits offered by my employer and decline to elect. I understand that if in the future if I wish to participate in the coverages herein declined, I will have to wait until the next annual open enrollment period unless I have a qualifying life event. And that I must notify my HR department with 30 days of the eligible qualified life event.

Section 8: Acknowledgements, Authorizations & Signature

I, hereby request the amount(s) and form(s) of the coverage for which I am eligible under the plans of my employer and I authorize same to deduct the required contribution, if any, from my earnings. I further certify that the statements herein are complete and accurate to the best of my knowledge. I understand benefits could be affected, reduced, or terminated if I knowingly provide false, incomplete, or misleading information on this form. I understand and agree that, under no circumstances, does this form extend the obligations of the plan to benefits that would otherwise be outside the scope of the plan document. I understand and agree that this form does not create any contractual rights or obligations between the plan and other parties to plan benefits that would otherwise be outside the scope of the plan document. The language within the plan document controls the operation of the plan.

Authorization to receive Federal Notices: I have received all required Federal notices in the current Open Enrollment booklet and I hereby give permission for any and all Federal or State required notices to be sent to me electronically. I also understand that I have access to the notices on the intranet. If I would like to request a paper copy of any notices, these are available to me by contacting my HR Department.

Authorization to release information: I hereby give permission that any providers of healthcare services, claim administrators, insurers, reinsurers and others who have a legitimate need for such information for the purpose of review, investigation or evaluation of a claim, to supply each other with information about my (or my covered dependent participants, if applicable) health status and the healthcare services provided to me (or my covered dependent participants, if applicable). I agree that a photographic copy of this permission is as valid as the original.

Signature & Date: _____

Employer Notes: