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**Authorization for Employee Deductions Form**

**Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­**

**CareFirst Option 4 HSA BlueFund, $1,500 (pre-tax deduction)**

Individual Employee Coverage (SCG paid)

Employee + Child(ren) $416.74/month or $208.37/pay period

Employee + Spouse $637.36/month or $318.68/pay period

Employee + Family $1,000.16/month or $500.08/pay period

**CareFirst HSA Elective Contribution (pre-tax deduction)**

I wish to have SCG withhold the following amount from my paycheck on a pre-tax basis as a contribution into my HSA account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/pay period

\*Eligible employees who are employed at SCG on December 1, 2016, and enroll in the new BlueFund HSA plan, will receive a one-time contribution in the amount of $1,000 from SCG into their HSA account by December 31, 2016.

**CareFirst BluePreferred Option 7 PPO, $250 (pre-tax deduction)**

Individual Employee Coverage $457.70/month or $228.85/pay period

Employee + Child(ren) $1,263.48/month or $631.74/pay period

Employee + Spouse $1,690.08/month or $845.04/pay period

Employee + Family $2,391.56/month or $1,195.78/pay period

\_\_\_\_ Waiving Medical Coverage (coverage provided through:  Spouse  Parents  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_ I certify that I am covered for health benefits under another plan and therefore waive my right to be covered under the group health plans offered by SCG. I understand that if I wish to participate at a later date, I may be required to furnish a HIPPA certificate of prior coverage as a condition for coverage or I may have a waiting period for any pre-existing conditions

Coverage is provided through (provider name and effective date of coverage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Humana Dental Insurance (pre-tax deduction)**

Employee $38.70/month ($19.35/pay period)  
 Employee + Chil(ren) $74.40/month ($37.20/pay period)  
 Employee + Spouse $87.96/month ($43.98/pay period)  
 Employee + Family $125.16/month ($62.58/pay period)

\_\_\_\_ Waiving Dental Coverage

**Humana Vision Insurance (pre-tax deduction)**

Employee $5.52/month ($2.76/pay period)  
 Employee + Chil(ren) $10.50/month ($5.25/pay period)  
 Employee + Spouse $11.04/month ($5.52/pay period)  
 Employee + Family $16.50/month ($8.25/pay period)

\_\_\_\_ Waiving Vision Coverage

**Reliance Standard (post-tax deduction)**

Supplemental Life/AD&D Insurance (please calculate cost and enter amount here)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplemental Life/AD&D Insurance – Spouse (please calculate cost and enter amount here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplemental Life/AD&D Insurance – Child (please calculate cost and enter amount here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Short Term Disability – Employee (please calculate cost and enter amount here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Waiving Supplemental Ancillary Coverage

**Authorization for Employee Deductions**

I understand and agree that the deductions I have requested above will be taken out of my pay check in accordance with the company’s section 125 plan on a pre-tax basis (medical, dental and vision deductions only) and on a post-tax basis (Life/AD&D/STD deductions only).

Yes  No  N/A

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_