PUTNAM COUNTY CHARTER SCHOOL SYSTEM — inspire. innovate. excel.

WORKSHEET for ENROLLMENT NEW HIRES 7/1/2026 – 6/30/2027 Plan Year

Employee Name	☐ Female ☐ Male	☐ Married ☐ Single	Birth date (Mo. Day, Yr.)	Hire Date (Mo. Day, Yr.)
Address	Employee ID	Social Security Number		Effective Date
City State Zip	Occupation/Location			Annual Earnings $
Paymode ☒ Monthly ☐ Bi-Weekly	Home Phone (or Cell)	Email Address		
☐ New Employee or Annual Enrollment	Change Due To: ☐ Marriage ☐ Death ☐ Adoption ☐ Name Change ☐ Birth ☐ Divorce ☐ Terminated ☐ Other New Hire	Actively at work? ☐ yes ☐ no		☐ COBRA ☐ Retiree

▶ **Primary Beneficiary for Basic & Supplemental Group Life Insurance**	**Relationship**
▶ **Contingent Beneficiary for Basic & Supplemental Group Life Insurance**	**Relationship**

I ELECT TO RECEIVE THE FOLLOWING COVERAGES UNDER THE CAFETERIA PLAN ON A "PRE-TAX" BASIS:
I and my employer hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the plan year that remains after the date of this agreement). On this or the appropriate form(s), I have enrolled for the below benefits.

		Mo. Deduction
Medical Insurance State Health Benefit Plan	Complete SHBP enrollment through www.myshbpga.adp.com no more than 31 days from your START date	$ ☐ Decline
Dental Insurance MetLife	**High Option** ☐ Employee $41.23 ☐ Emp & Spouse $79.32 ☐ Emp+ Children $103.03 ☐ Full Family $139.87 **Low Option** ☐ Employee $35.51 ☐ Emp + Spouse $68.51 ☐ Emp + Children $81.01 ☐ Full Family $114.06	$ ☐ Decline
Vision Insurance Avesis Vision 20790-1326	☐ Employee Only $7.30 ☐ Employee + 1 $14.16 ☐ Full Family $21.08	$ ☐ Decline

Covered Dependents

Dental	Vision	Life	Last Name, First Name, Middle Initial	Relationship	Birthdate	SSN
☐	☐	☐		**Spouse**		
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				

Medical Flexible Spending Account Annual Maximum is $3,400 Enter per pay period amount to be deducted. Not to exceed $283.33 per month		$ ☐ Decline
Dependent Care Flexible Spending Account Annual Maximum is $7,500- Enter per pay period amount to be deducted. Not to exceed $625 per month		$ ☐ Decline
Cancer Insurance- Standard *Enroll with Houze Counselor*	**High Plan** ☐ Employee $26.04 ☐ Family $43.96 **Low Plan** ☐ Employee $12.36 ☐ Family $20.96	$ ☐ Decline
Critical Illness with Cancer – VOYA	Employee ☐ $10,000 ☐ $20,000 Child(ren) ☐ $5,000 ☐ $10,000 Spouse ☐ $5,000 ☐ $10,000 (not to exceed 50% of employee) ☐ ***TOBACCO?***	$ ☐ Decline
Accident Insurance- VOYA	☐ Employee $11.99 ☐ Employee & Spouse $15.84 ☐ Employee & Children $22.24 ☐ Family $26.09	$ ☐ Decline

Hospital Insurance- VOYA

	Employee	EMP & Spouse	EMP & Child(ren)	Family
$100 Daily Benefit	☐ $10.02	☐ $18.03	☐ $17.26	☐ $25.27
$200 Daily Benefit	☐ $18.79	☐ $41.33	☐ $41.55	☐ $64.09
$300 Daily Benefit	☐ $27.28	☐ $60.01	☐ $59.63	☐ $92.36

$ ☐ Decline

I ELECT TO RECEIVE THE FOLLOWING ADDITIONAL COVERAGES ON AN "AFTER-TAX" BASIS:
Prior to the beginning of each plan year, I will have the opportunity to enroll, cancel or change the following coverage.

Sick Leave Bank	Employees will be eligible to become a member of the sick leave bank at the Annual Enrollment following one (1) year of employment by donating one (1) day of accumulated sick leave.	N/A
Basic Group Life Insurance– Voya/Reliastar **$30,000 Provided for all Full Time Employees under age 70** ($12,500 age 70 – 74 and $8,750 over age 75)		No Cost

Employee Group Life Insurance- Voya/Reliastar *$20,000 to $500,000 not to exceed 5 times salary;* ***$100,000 GI only, over requires EOI*** Rates are per $10,000 : <30 $0.80 30-34 $0.90 35-39 $1.10 40-44 $1.70 45-49 $2.90 50-54 $4.90 55-59 $7.60 60-64 $11.90 65-69 $21.30 > 70 $38.20	Amount: _____ (100,000 GI Only) Rate based on age:_____ Monthly: _____	$ ☐ Decline
Employee Accidental Death Insurance- Voya/Reliastar ***Must Equal the Employee Group Life Insurance*** *Coverage is not to exceed $250,000 or 5x earnings* $0.40 per $10,000	Amount : _____ Rate: .40/$1000:_____ Monthly: _____	$ ☐ Decline
Spouse Group Life Insurance- Voya/Reliastar *$10,000 to $500,000 not to exceed 5x employee salary;* ***$30,000 GI, over requires EOI*** Rates are per $10,000: <30 $0.80 30-34 $0.90 35-39 $1.10 40-44 $1.70 45-49 $2.90 50-54 $4.90 55-59 $7.60	Amount: _____ (30,000 GI Only) Rate based on age:_____ Monthly: _____ ****Spouse cannot also be a Putnam Employee***	$ ☐ Decline
Spouse Accidental Death Insurance- Voya/Reliastar ***Must Equal Spouse Group Life Insurance*** *Coverage is not to exceed $250,000/5x employee earnings* $0.40 per $10,000	Amount : _____ Rate: .40/$1000:_____ Monthly: _____	$ ☐ Decline
Dependent Group Life Insurance ***Employee must elect Group Life Insurance to be eligible and the covered dependent can't also be a Putnam Employee***	**Plan 1** ☐$1.25 for $5000 **Plan 2** ☐$2.50 for $10,000 Plan covers all children ages 6 months to 19, or 25 if full time student. Children 15 days – 6 months have $500 (Plan 1) or $1000 (Plan 2)	$ ☐ Decline
Short Term Disability- Voya/Reliastar 60% of salary up to $1,000 per week, payable for 1st day Hospital and either 15 or 31 days without hospitalization for up to 26 weeks. Rates based on $10 weekly benefit	Age / 15th Day ☐ / 31st Day ☐ ☐ <39 / $.54 / $.43 ☐ 40 - 54 / $.62 / $.50 ☐ 55 - 64 / $1.02 / $.81 ☐ >65 / $1.38 / $1.10	Salary _____ Times .6 _____ Divide by 52 (____) *(not to exceed $750)* Divide by 10 (___) Times Rate (____) = Cost	$ ☐ Decline
Long Term Disability- Voya/Reliastar 60% of salary up to $5000 month payable after 181 days (6 months) to age 65. Rates are based on $100 monthly earnings ☐ <30 $.10 ☐ 30-34 $.14 ☐ 35-39 $.22 ☐ 40-44 $.30 ☐ 45-49 $.42 ☐ 50-54 $.51 ☐ 55-59 $.60 ☐ > 60 $.90		Salary _____ Divide 100 _____ Times Rate (____) =_____ Divide by 12 = Cost	$ ☐ Decline

About Proof of Good Health Questionnaire:

You must complete a Health Questionnaire if you apply for in excess of $100,000 of Employee Group Supplemental Life, or Spouse Life application is over $30,000. If you decline coverage when first eligible or hired, a Health Questionnaire must be completed for any future election or increase in the amount of employee, spouse or dependent life insurance. Coverage over Guarantee Issue will not be in effect until the carrier has approved the application.

Disability Insurance:

STD: There is a 6 month wait for any disability coverage that is considered pre-existing. A pre-existing condition is one that has been treated or sought treatment for an accident or illness for 3 months prior to the effective date of the plan. Any pre-existing disability will not be covered for 6 months from the effective date of the plan.

LTD: There is a 12 month wait for any disability coverage that is considered pre-existing. A pre-existing condition is one that has been treated or sought treatment for a accident or illness for 3 months prior to the effective date of the plan. Any pre-existing disability will not be covered for 12 months from the effective date of the plan.

Notice:

Please refer to policy booklets and certificates for exact details/limitations as provided by Putnam County Schools.

IMPORTANT: You must read and sign to apply for coverage.

If I decline employee, dependent or spouse coverage now or want an increase in coverage at a later date with the exception of a qualifying event, I will have to provide evidence of insurability acceptable to the carrier.

I UNDERSTAND that if my required contributions for the selected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect the change. Prior to the first day of each plan year, I will have the opportunity to change my benefit elections for the following plan year. If I do not complete and submit a new election form prior to a new plan year, I will be treated as having elected to continue my benefit elections then in effect for the new plan year. In addition, I understand changes in the elected deduction and benefits can only be made in the event of a Section 125 qualifying event.

Date _____ **Signature** _____