Moore College of Art and Design-Staff
Employee Election Form
November 1, 2025 through October 31, 2026

Personal Information: Date of Hire: / /

Last Name First Name Middle Initial

Home Address: Street City State Zip

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Please elect from the following options: Local Employees Only
Monthly Payroll Deduction (12 pays):

	Medical Only		Dental Only
	HBT HMO 20/40	**HBT PPO 20/40**	**Guardian**
Employee	☐ $149.23	☐ $249.63	☐ $0.00
Employee & Spouse	☐ $1,286.63	☐ $1,532.63	☐ $53.68
Parent/Child(ren)	☐ $816.03	☐ $1,001.73	☐ $55.21
Family	☐ $1,757.33	☐ $2,063.53	☐ $108.84

	Medical & Dental	
	HBT HMO 20/40	**HBT PPO 20/40**
Employee	☐ $149.23	☐ $249.63
Employee & Spouse	☐ $1,340.31	☐ $1,586.31
Parent/Child(ren)	☐ $871.24	☐ $1,056.94
Family	☐ $1,866.17	☐ $2,172.37

☐ Waive Medical Coverage - Please complete the attached waiver form and submit a copy of your current identification card.
☐ Waive Dental Coverage - Please complete the attached waiver form.

Salary Redirection Agreement
I have read and understand the explanation I have received regarding my options under the Moore College Health Care Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my family status. A change in family status includes: marriage; divorce; death of a spouse or dependent; birth or adoption of a child; or a change in you or your spouse's employment status.

I hereby apply for the options listed above. If necessary, I authorize Moore College to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from November 1, 2025 through October 31, 2026, unless my family status changes.

_____ _____
Employee Signature Date

_____ _____
Company Representative Date

***All employees* must complete this form and return it to the Human Resources Department no later than Friday, September 19, 2025.**

Moore College of Art and Design
Verification of Other Medical Coverage

Employee Name _____

I understand that I am eligible for health care and dental coverage provided by Moore College. The medical benefits under such plans and the contributions I would have to make to be covered for these benefits have been explained to me in detail.

I certify that I have medical/dental benefits under another group insurance plan:

Full name of principal insured (and relationship) _____

Name of organization providing coverage (i.e., an employer) _____

Address _____

Insurance Carrier _____

Group Number _____

I, therefore, decline coverage for the full year November 1, 2025 through October 31, 2026 under the health care plans offered by Moore College for myself and any eligible dependents.

I waive all claims to ☐ medical and/or ☐ dental benefits under Moore College Health Care Plans.

I understand that if I choose to enroll for the benefits at a later date, I (and/or my dependents) may be subject to limitation for preexisting conditions and required to furnish evidence of good health in order to be covered. Under some circumstances, coverage may be denied. Coverage will generally be available during the annual open enrollment period, but if you enroll, pre-existing condition limitations may apply.

I further understand that, as a result of this waiver, no medical/dental coverage under any of the Moore College Health Plans will be provided. I hereby release, and hold Moore College, and any health plans of Moore College and any Administrators of said plan, harmless for any claims as a result of the failure of refusal to provide medical benefits in accordance with this waiver.

I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct, and complete; and I agree that medical/dental benefits under the Moore College Health Care Plans will be denied for my submission of any false information on this Verification or any other form.

_____ _____

Employee Signature Date

_____

Witness