**\*\* Ability One Contract Employees\*\***

**2018 Fringe Benefit Election Form**

Employee Name

Employees paid through Ability One contracts are eligible for health and welfare benefits for each hour worked. This benefit is paid by the government to allow us, the employer, to assist you in paying for benefits or retirement.

As an employee of Goodwill Industries, you have choices as to how you would like this fringe benefit money spent on your behalf. Your options are shown below. Any remaining funds will be placed into a 401(a) retirement account in your name.

*\*see plan details*

* Health insurance *\*employees must be Full Time to be eligible for health insurance*

# Dental benefits

* Vision benefits
* Life insurance: Through USAble or MetLife

(Critical Illness, Accident, Short Term Disability, and FSA are not eligible for H&W funds)

Important points to remember:

* If there is a change in the number of hours worked per week and your insurance deductions are more than your benefit amount, the amount you owe to us will be automatically deducted from payroll.
* If you elect to use the fringe benefit money to cover insurance premiums, you are required to remain enrolled in the insurance until the next open enrollment, unless you have a change in status (marriage, divorce, new baby, etc).
* If you choose to pay for insurance premiums through this fringe benefit money, any remaining money will be placed automatically into a 401(a) retirement account in your name. These funds will not be accessible until you have been separated from the Agency for one year, or you are at least 60 years old.

Below is chart where you can calculate your benefits, considering your fringe benefit amounts. Please take the time to go through this with your case manager prior to open enrollment.

**This worksheet is for estimation purposes only**. The hours worked and the corresponding fringe benefit amount for both premiums and the 401a account are **not guaranteed**.

|  |  |  |
| --- | --- | --- |
| Hours worked per month=  | Fringe Benefit Amount =$4.41 /hour | Amount of Fringe Benefit/pay period =$  |
| Dental premium per pay period | $ / pay period | Dental Premium minus (-) above amount$  |
| Health premium per pay period | $ / pay period | Health Premium minus (-) above amount$  |
| Life premium per pay period (USAble and/or Assurant) | $ / pay period | Life Premium minus (-) above amount$  |
| Vision premium per pay period | $ / pay period | Vision Premium minus (-) above amount$  |
| Amount into 401a plan each month = |  | Remaining Amount: |

By signing this, I indicate my understanding of the fringe benefit and that I have made the choice of how I would like this benefit spent on my behalf. I understand that I may not change my election or drop this benefit at any time during the calendar year, unless I terminate my employment with the Agency or have a change in status. Fringe benefits will not be paid in cash.

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**Name**  **Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**