Pennington County Health-Dental-Vision Benefit Open Enrollment- 2025 Plan Year

Employee Name: _____DOB:_____

Address: _____SSN:_____

City/State/Zip: _____ Marital Status: _____

Phone #: _____ E-mail Address: _____

Traditional PPO	High Deductible	Dental Only Rates	Vision: Materials Only	Vision: Exam + Materials
Single $63.93	Single $35.89	Single $5.01	Single $7.04	Single $10.93
2-Party $197.36	2-Party $115.96	2-Party $20.35	2-Party $13.38	2-Party $20.77
Family $382.37	Family $226.29	Family $26.72	Family $19.64	Family $30.49

**Dollar amounts are employee premium amounts.*

Wellmark Health Insurance Benefits

◯ I wish to make changes to my current enrollment.

◯ Traditional PPO ◯ High Deductible Plan

◯ Single Coverage
◯ 2- Party Coverage
◯ Family Coverage

◯ I do not wish to participate in health insurance for the 2025 plan year.

Delta Dental Insurance Benefits

**You must enroll in the same level or a higher level of Dental Insurance if enrolled in Health Insurance.*

◯ I wish to make changes to my current enrollment.

◯ Single Coverage
◯ 2- Party Coverage
◯ Family Coverage

◯ I do not wish to participate in dental insurance for the 2025 plan year.

Supplemental Vision Insurance Benefits

◯ wish to make changes to my current enrollment.

◯ Materials Only ◯ Exam + Materials

◯ Single Coverage
◯ 2- Party Coverage
◯ Family Coverage

◯ I do not wish to participate in vision insurance for the 2025 plan year.

Please list your spouse and/or eligible dependents and their information below.
Please only list those you wish to cover.

Name	DOB	SSN	Gender	Full-Time Student?	Medicare Enrolled?	Other Coverage?	Relationship

If any of the above enrollees has Medicare or other coverage please provide a copy of that Medicare or Health Care Coverage Card to our office.

Policy Holders Name_____ Policy #_____

Carrier Name_____ Address_____

Coverage Effective Date_____ Coverage End Date_____

Did anyone over the age of 19 you elected to enroll in our health care benefits have insurance coverage within the last 63 days? If yes, please list those names below and provide a certificate of credible coverage from that provider to our office.

Names: _____

Health Savings Account – Only for High Deductible Plan Members/Enrollees

This may be used for qualified out-of-pocket health care expenses that are not covered by my employer's health plan or any other health plan.

◯ I would like to enroll in a Health Savings Account for plan year 2025.

My **bi-weekly** election amount is: ☐

Single Coverage Annual Max $ 4,300

Family Coverage Annual Max $ 8,550

◯ I do not wish to participate in a health savings account for the 2025 plan year.

Employee Acknowledgment

I understand that the plan changes or elections made on this form will be effective beginning **January 1st, 2025** for the 2025 plan year and that I may only make changes to these elections within 31 days of a qualifying event, during an Open Enrollment period, or upon termination of my employment. I understand that all contributions and premiums will be deducted on a pre-tax basis. I understand that my first 2025 premium will be deducted from my December 2024 payroll. I certify that I am legally authorized to apply for coverage for myself and all other persons named on this form and that I have verified all the information on this form is accurate to the best of my knowledge. I understand that all information provided on this form will be entered as is by Human Resource personnel. I will be responsible for notifying Human Resources of any changes to ensure accurate records are maintained. If additional information was requested, I understand that failure to submit those items may result in a delay or cancellation of coverage.

Employee Signature: _____ Date: _____

Entered By (HR):_____ Date: _____