Inserra Supermarkets
2024 Associate Benefit Enrollment
Associate Plan Menu and Contributions

☐ New Hire ☐ Life Event ☐ Open Enrollment

Associate Name: #300 Number:

Social Security Number: Date of Birth:

Home Address:

City: State: Zip:

Signature: Date:

ACO Network

Aetna Whole Health

Basic Managed Choice Plan (Bronze)
Associate Contributions (Weekly)
☐ Associate Only: **$19.01**
☐ Associate + Family: **$32.68**

Managed Choice Plan (Silver Plus)
Associate Contributions (Weekly)
☐ Associate Only: **$56.44**
☐ Associate + Family: **$132.33**

HCRA Plan (Aetna Healthfund)
Associate Contributions (Weekly)
☐ Associate Only: **$32.08**
☐ Associate + Family: **$67.25**

Broad Network

Basic Managed Choice Plan (Bronze)
Associate Contributions (Weekly)
☐ Associate Only: **$22.81**
☐ Associate + Family: **$39.21**

Managed Choice Plan (Silver Plus)
Associate Contributions (Weekly)
☐ Associate Only: **$67.73**
☐ Associate + Family: **$158.80**

HCRA Plan (Aetna Healthfund)
Associate Contributions (Weekly)
☐ Associate Only: **$38.50**
☐ Associate + Family: **$80.69**

☐ **Medical Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

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Associate Name:

Dental: MetLife

MetLife Dental Plan

Associate Contributions (Weekly)

- ☐ Associate Only: **$0.00**
- ☐ Associate + Family: **$0.00**
- ☐ **Dental Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

Vision: EyeMed

EyeMed Vision Plan: Option 1

Associate Contributions (Weekly)

- ☐ Associate Only: **$0.00**
- ☐ Associate + One Eligible Dependent: **$0.00**
- ☐ Associate + Family: **$0.00**

EyeMed Vision Plan: Option 2

Associate Contributions (Weekly)

- ☐ Associate Only: **$0.55**
- ☐ Associate + One Eligible Dependent : **$1.21**
- ☐ Associate + Family: **$2.17**

☐ **Vision Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

Flexible Spending Account (FSA) Health Care

☐ Elect Coverage $

Dependent Care

☐ Elect Coverage $

☐ **FSA Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

For administration use only.

Associate Hire Date:

Effective Date:

Effective Date Notes:

Billing Store:

Additional Notes:

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Associate Name:

Dependent Enrollment

Please attach applicable Marriage Certificate/Birth Certificate for anyone you are adding.

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

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