

BENZIE COUNTY CENTRAL SCHOOLS

Medical Plan and HSA Election Form
Plan Year: 2027

Employee Name: _____

Date: _____

Plan Election

Check the plan you are electing:

☐ Option 1: BCBSM 100% PPO — $2,000 / $4,000

☐ Option 2: BCBSM 80% PPO — $1,750 / $3,500

☐ Option 3: BCBSM 100% PPO — $2,500 / $5,000

☐ Option 4: Priority Health 100% POS — $2,500 / $5,000

Any changes to enrolled dependents? ☐ YES ☐ NO

District-Funded HSA Election

Are you electing to receive a District-funded HSA contribution?

☐ YES ☐ NO

If **YES**, indicate the flat dollar amount below (e.g., $200, $550, etc.).
Do not exceed:
- $1,400 for a Single subscriber plan
- $2,800 for a Two-Person or Family plan

HSA Amount Elected: $_____

Acknowledgment

I understand that:
- My elections are final and cannot be changed once submitted.
- Any elected District-funded HSA contribution will increase my per-pay insurance deduction.
- If my employment ends prior to completion of my contract, I am responsible for repaying any unpaid portion of the District-funded HSA contribution.

Employee Signature: _____ Date: _____