



2022/2023 Medical/Dental Election Memo

Part 1

Medical Insurance *Please check applicable plan or waive coverage*



Simply Blue 25-500	
Employee	<input type="checkbox"/>
Family	<input type="checkbox"/>
If you or Spouse are Medicare eligible & you elect this plan; the Prescription Coverage is Credible .	

Signature Hybrid 1	
Employee	<input type="checkbox"/>
Family	<input type="checkbox"/>
If you or Spouse are Medicare eligible & you elect this plan; the Prescription Coverage is Non-Credible . Which means you will have a 1% premium penalty of the Part D Premium each month you are your Spouse do not have Credible Coverage.	

Signature Ded. 3	
Employee	<input type="checkbox"/>
Family	<input type="checkbox"/>
If you or Spouse are Medicare eligible & you elect this plan; the Prescription Coverage is Credible .	

I waive my employer's group **MEDICAL** insurance coverage for myself and my dependents (if any).

Part 2

Dental Insurance *Please check applicable plan or waive coverage*



Option 1 (High)	
Employee	<input type="checkbox"/>
Employee & One	<input type="checkbox"/>
Family	<input type="checkbox"/>

Option 2 (Low)	
Employee	<input type="checkbox"/>
Employee & One	<input type="checkbox"/>
Family	<input type="checkbox"/>

I waive my employer's group **DENTAL** insurance coverage for myself and my dependents (if any).

Part 3

Department *Please check*

<input type="checkbox"/> ADM	<input type="checkbox"/> CDS	<input type="checkbox"/> ES	<input type="checkbox"/> FDD	<input type="checkbox"/> HS	<input type="checkbox"/> EHS	<input type="checkbox"/> WIC
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PRINT Employee Name

Employee Signature

Date

***PLEASE NOTE: IF THERE ARE ANY CHANGES IN YOUR HEALTH INSURANCE POLICY; A NEW APPLICATION WILL NEED TO BE COMPLETED. FOR EXAMPLE: ADD OR DELETE A DEPENDENT; ADDRESS CHANGE.**

Email gahelp@gahealth.org or call (315) 701-0244 if you have any questions.