Easton **H**ellertown **Q**uakertown

CIRCLE YOUR WORK LOCATION

Eligibility Date: _____/_____/_____

1ST of the month where first 90 days of permanent employment falls.

Star Premium Benefits Coverage (Standard)

1/1/2021-12/31/2021

(See Benefit Plan Summary for details.)

Employee Name: _____

Listed below are the 26 **bi-weekly** premium healthcare options starting _____/_____/_____

	Employee	Employee &/Spouse)	Employee & Child / Children	Employee & Family
Circle Your Selection				
LV Flex Blue HSA 4000	**$79.95**	$309.95	$319.95	$499.95
LV Flex Blue PPO 2000	**$111.95**	$369.95	$379.95	$539.95
LV Flex Blue PPO 1000	**$129.95**	$399.95	$439.95	$579.95
Dental Plan until 06/30/21:	**$11.32**	$37.55	$37.55	$37.55
Vision Plan until 06/30/21:	**$1.67**	$4.98	$4.98	$4.98

I choose to be enrolled in the above circled plan offered by the Star Dealerships: _____

I decline coverage _____

Spousal Employment Affirmation

If you are married and your spouse is employed full time and has Medical/Rx coverage available to him/her. I understand that my spouse is not considered an eligible dependent under my Medical/RX coverage. Initial _____

401K: You have the option to enroll in a 401K Retirement plan after 1 year of employment. Please let HR know of your intent to enroll or waive your 401K plan.

_____I wish to enroll in the 401(k) Retirement Plan.

_____ I am **declining** participation in the 401(k) Retirement Plan.

IMFORMATION ABOUT THE ACA GOVERNMENT HEALTHCARE MARKETPLACE CAN BE FOUND AT: www.healthcare.gov

Employee Signature: _____ Date: _____

Employee Print Name: _____

NOTE:

12/04/2020 rpg