EMPLOYEE NAME:_____

Please make your plan elections below for the 2025 plan year, by marking an 'X' next to your plan selection. If waiving coverage, select the waive option at the bottom of each coverage option.
This form must be returned to Celeste Westfall by November 25, 2024.
For additional guidance view the City of Brooklyn benefits site at www.mycityofbrooklynbenefits.com

MEDICAL				
Tier of Coverage	Monthly Premium	Employee Monthly Contribution	Employee Per Pay Contribution	Employee Election (x)
$250 PPO Plan				
EE	$781.64	*$89.89*	*$41.49*	
ES/DP	$1,561.01	*$179.52*	*$82.85*	
ECHILD(REN)	$1,482.89	*$170.53*	*$78.71*	
FAMILY	$2,262.29	*$260.16*	*$120.08*	
$1000 PPO Plan				
EE	$663.20	*$59.69*	*$27.55*	
ES/DP	$1,324.48	*$119.20*	*$55.02*	
ECHILD(REN)	$1,258.20	*$113.24*	*$52.26*	
FAMILY	$1,919.50	*$172.76*	*$79.73*	
$250 CLECARE Plan				
EE	$714.03	*$42.84*	*$19.77*	
ES/DP	$1,425.98	*$85.56*	*$39.49*	
ECHILD(REN)	$1,354.62	*$81.28*	*$37.51*	
FAMILY	$2,066.61	*$124.00*	*$57.23*	
H.S.A. Plan				
EE	$569.26	*$17.08*	*$7.88*	
ES/DP	$1,136.87	*$34.11*	*$15.74*	
ECHILD(REN)	$1,079.98	*$32.40*	*$14.95*	
FAMILY	$1,647.61	*$49.43*	*$22.81*	

WAIVING MEDICAL		
	PARTIAL	FULL

DENTAL				
Tier of Coverage	Monthly Premium	Employee Monthly Contribution	Employee Per Pay Contribution	Employee Election (x)
EE	$22.58	*$2.60*	*$1.20*	
ES/DP	$46.07	*$5.30*	*$2.45*	
ECHILD(REN)	$65.75	*$7.56*	*$3.49*	
FAMILY	$94.41	*$10.86*	*$5.01*	

WAIVING DENTAL		
	PARTIAL	FULL

VISION				
Tier of Coverage	Monthly Premium	Employee Monthly Contribution	Employee Per Pay Contribution	Employee Election (x)
EE	$3.41	*$0.39*	*$0.18*	
ES/DP	$6.86	*$0.79*	*$0.36*	
ECHILD(REN)	$6.48	*$0.75*	*$0.34*	
FAMILY	$9.91	*$1.14*	*$0.53*	

WAIVING VISION		
	PARTIAL	FULL

Employee Signature

Date