Employee Benefits Selection Form

Employee Name

Employee ID

Date

Health Insurance

Choose one:

- ☐ Plan A: High deductible, lower premium
- ☐ Plan B: Medium deductible, medium premium
- ☐ Plan C: Low deductible, higher premium

Dental Insurance

☐ Yes ☐ No

Vision Insurance

☐ Yes ☐ No

Retirement Plan

401(k) Contribution: _____ % of salary

Flexible Spending Account (FSA)

Annual contribution: $ _____

Life Insurance

Coverage amount: $ _____

Disability Insurance

☐ Short-term ☐ Long-term

☐ Both ☐ None

Additional Benefits

Select all that apply

- [ ] Childcare subsidy
- [ ] Elder care support
- [ ] Fertility treatment coverage
- [ ] Gender affirmation procedure coverage
- [ ] Mental health support
- [ ] Professional development fund
- [ ] Student loan repayment assistance
- [ ] Other: _____

Flexible Work Arrangements

Select all that apply

- [ ] Remote work option
- [ ] Flexible hours
- [ ] Compressed workweek
- [ ] Job sharing
- [ ] Other: _____

Feedback on Benefits Offerings

What additional benefits would you find valuable?

Cost Calculator

Total Annual Premium Costs: $ _____

Total Annual Contributions: $ _____

Estimated Tax Savings: $ _____

Confirmation

I confirm that I have reviewed and understand my benefits selections:

_____ _____

Employee Signature Date