

## AGMA Health Fund

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## AGMA Health Fund Open Enrollment 2022 Form

Please submit your Open Enrollment 2022 Form before November 30. Although you can submit a paper copy, we prefer that you complete it online at [portal.agmaretirement-health.org](https://portal.agmaretirement-health.org).

If you have any questions, please contact the Fund Office at (212) 765-3664 or email us at info@agmafunds.org.

Health Plan Selection (each participant must choose one). Please note that you may only select Plan A1 if you are covered by a collective bargaining agreement that permits that choice.

- |  |   |
|--|---|
| <input type="checkbox"/> Plan A (individual) | <input type="checkbox"/> Plan A1 (individual) |
| <input type="checkbox"/> Plan A (family)     | <input type="checkbox"/> Plan A1 (family)     |

If I have selected Plan A (individual or family coverage), I acknowledge that I must contribute \$40 per month and agree that my employer will deduct this amount to be included with each employer contribution.

- Please check this box if you have selected Plan A, and you elect to use your available Plan B balance to pay the \$40 per month member contribution directly.

If I have selected Plan A1 (individual or family coverage), I acknowledge that I may elect to have my employer deduct an additional amount from my paycheck to be contributed to my Health Savings Account, and that I am responsible to ensure that contributions to my HSA do not exceed the applicable IRS maximums for the calendar year. For 2022, those maximums are \$3,650 for individual coverage and \$7,300 for family coverage.

- I wish to have an additional voluntary HSA deduction of \_\_\_\_\_ during 2022 from my paycheck.

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Optional Coverage:

- |  |   |
|--|---|
| <input type="checkbox"/> Dental (individual) \$22.62 per month | <input type="checkbox"/> Vision (individual) \$3.19 per month |
| <input type="checkbox"/> Dental (family) \$64.80 per month     | <input type="checkbox"/> Vision (family) \$7.61 per month     |
- 

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If this form is not completed online or returned by 8:00pm ET on November 30, 2021, participants will be enrolled in Plan A coverage at their current individual or family level and will be responsible for having the \$40 monthly fee deducted and remitted by their employer with the monthly employer contribution.*