AGMA | Health Fund & Retirement Plan

AGMA HEALTH FUND BENEFITS

Full Name _____
Address _____
Date of Birth _____
Social Security# _____
Gender _____
Mobile# _____
Email _____

Health Plan Selection

Each participant must choose one. Please note that you may only select ***Healthy Savings Plan*** if you are covered by a collective bargaining agreement that permits that choice.

☐ Standard Plan – Individual
☐ Standard Plan – Family
☐ Healthy Savings Plan – Individual
☐ Healthy Savings Plan – Family

If you selected the Healthy Savings Plan:

If I have selected Healthy Savings Plan (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 2026, those maximums are $4,400 for individual coverage and $8,750 for family coverage.

Please enter amount of voluntary contribution: _____

AGMA Health Fund Office
60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222
877-578-8703|AGMAFunds@cdsadmin.com

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Optional Dental Coverage

- ☐ PPO Base Plan - Individual
- ☐ PPO Base Plan - Family
- ☐ PPO Buy-Up Plan - Individual
- ☐ PPO Buy-UP Plan - Family

Optional Vision Coverage

- ☐ **Individual**
- ☐ **Family**

_____ _____

Signature Date

If you elected any family plan options, be sure to include all relevant documentation for your dependents. (See below for more details.) Your dependents will not be enrolled if we do not receive all necessary documents.

Enrolling dependents?

You will need to provide copies of the following if you are adding dependents to your plan:

- ☐ Social security cards
- ☐ Marriage certificate (for spouse)
- ☐ Birth certificate(s) (for children)

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Questions;

If you have any questions, please contact the Fund Office at 877-578-8703 or email us at AGMAFunds@cdsadmin.com.

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