



Enrollment Form 2020

This Enrollment form lists your benefit options and corresponding payroll deductions. Use this form to elect or decline your benefit options. PLEASE PRINT.

EMPLOYEE INFORMATION

Name		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		Birth date (MM/DD/YYYY)	/ /
City		Social Security Number	- -
State			
Zip		Date Employed	/ /
Cell Phone Number		Department/Occupation	
Home Phone Number		Employee Status	<input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time <input type="checkbox"/> Retiree
Email Address		Hours worked per week	
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Never been married		
Authorized to work/reside in the United States	<input type="checkbox"/> Yes <input type="checkbox"/> No		

REASON FOR ELECTING OR CHANGING BENEFITS

Open Enrollment Period	<input type="checkbox"/> Yes	Status Change	<input type="checkbox"/> Birth	<input type="checkbox"/> Spouse lost coverage under another plan
New Employee	<input type="checkbox"/> Yes		<input type="checkbox"/> Adoption	<input type="checkbox"/> Spouse changed coverage under another plan
Address Change	<input type="checkbox"/> Yes		<input type="checkbox"/> Marriage	<input type="checkbox"/> Dependent lost coverage under another plan
			<input type="checkbox"/> Divorce	<input type="checkbox"/> Other
			<input type="checkbox"/> Death	

BENEFIT ELECTIONS

Pay Cycle: Weekly 48 payrolls/paychecks per year. If electing benefits after open enrollment period deductions are for remaining paychecks in year only.

MEDICAL BENEFITS

ELECTION	Traditional Deductible Plan	PER PAY AMT
<input type="checkbox"/> DECLINE BENEFITS	Police & Fire Employees All Other City Employees	
<input type="checkbox"/> SINGLE COVERAGE	<input type="checkbox"/> \$8.33/pay <input type="checkbox"/> \$1.00/annual	
<input type="checkbox"/> FAMILY COVERAGE	<input type="checkbox"/> \$25.00/pay <input type="checkbox"/> \$1.00/annual	
		\$

DENTAL BENEFITS (benefits are available through Delta Dental and are voluntary)

<input type="checkbox"/> DECLINE BENEFITS		
<input type="checkbox"/> SINGLE COVERAGE	<input type="checkbox"/> \$7.47/pay	
<input type="checkbox"/> EMPLOYEE + 1 (spouse or one child) COVERAGE	<input type="checkbox"/> \$14.44/pay	
<input type="checkbox"/> FAMILY COVERAGE	<input type="checkbox"/> \$28.96/pay	
		\$

VISION BENEFITS (benefits are available through VSP and are voluntary)

<input type="checkbox"/> DECLINE BENEFITS		
<input type="checkbox"/> SINGLE COVERAGE	<input type="checkbox"/> \$2.55/pay	
<input type="checkbox"/> EMPLOYEE + 1 (spouse or one child) COVERAGE	<input type="checkbox"/> \$3.90/pay	
<input type="checkbox"/> FAMILY COVERAGE	<input type="checkbox"/> \$6.99/pay	
		\$

BASIC LIFE/AD&D/LTD (benefits provided to you at no cost – benefits are available through OneAmerica)

<input checked="" type="checkbox"/> ELECT EMPLOYEE COVERAGE		
\$25,000 BENEFIT		

VOLUNTARY TERM LIFE - See enrollment guide for rates and instructions. Both employee and spouse rates are based on the employees age at or on July 1st of the current year. Rates do not change on your birthday. Some may move to the next higher rate on July 1st.

<input type="checkbox"/> DECLINE BENEFITS		
<input type="checkbox"/> EMPLOYEE COVERAGE	Minimum \$10,000/Maximum \$500,000 not to exceed 5x annual salary. Guaranteed Issue = \$150,000	See separate rate sheet.
<input type="checkbox"/> SPOUSE COVERAGE	Minimum \$10,000/Maximum \$25,000 Guaranteed Issue = \$25,000	See separate rate sheet.
<input type="checkbox"/> CHILD(REN) COVERAGE	Guaranteed Issue = \$10,000 – \$1,000 maximum death benefit for children under 6 months.	
<i>Select only one option</i>		
<input type="checkbox"/> Option 1 - \$2,500	<input type="checkbox"/> \$0.14/pay (rate is for one or multiple children)	
<input type="checkbox"/> Option 2 - \$5,000	<input type="checkbox"/> \$0.28/pay (rate is for one or multiple children)	
<input type="checkbox"/> Option 3 - \$7,500	<input type="checkbox"/> \$0.42/pay (rate is for one or multiple children)	
<input type="checkbox"/> Option 4 - \$10,000	<input type="checkbox"/> \$0.55/pay (rate is for one or multiple children)	
		\$0.00

TOTAL PER PAY AMOUNT \$

BENEFICIARY INFORMATION

This section must be completed to designate your beneficiaries for Basic Life/AD&D/VTL elections. If you designate multiple beneficiaries, indicate the percentage of benefit each is to receive. If no percentage are entered, each beneficiary will receive an equal share of the benefit.

ALL EMPLOYEES MUST COMPLETE THIS SECTION SINCE THE CITY OF GREENSBURG OFFERS ELIGIBLE EMPLOYEES BASIC LIFE/AD&D COVERAGE.

Beneficiary Name	Relationship to Insured	Beneficiary Birth Date	% of benefit

DEPENDENT INFORMATION

You need to provide information on all dependents whom you wish to cover for the benefits elected. In general, eligible dependents include your spouse and dependent children to age 26. See the definition of a dependent and other eligibility requirements in the plans Summary Plan Description booklet.

FAILURE TO PROVIDE COMPLETE INFORMATION MAY DELAY/PREVENT A DEPENDENT FROM BEING ENROLLED.

Name (First, Mi, Last)	SSN	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /	Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Coverage <i>(check all that apply)</i>			
						Medical	Dental	Vision	Life
SPOUSE	-	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life
CHILD	-	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life
CHILD	-	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life
CHILD	-	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life
CHILD	-	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life
CHILD	-	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life

OTHER COVERAGE INFORMATION

FAILURE TO PROVIDE COMPLETE INFORMATION MAY DELAY/PREVENT A DEPENDENT FROM BEING ENROLLED. FAILURE TO PROVIDE COMPLETE INFORMATION MAY DELAY/PREVENT A DEPENDENT FROM BEING ENROLLED.

As of your eligibility with this employer, do you or any eligible dependents have other medical/dental/vision coverage? Included Medicare/Medicaid? Yes No
If yes, please complete the following:

As of your eligibility with this employer, do you or any eligible dependent age 19 or above have other medical/dental/vision coverage available through another employer that has not been elected? Yes No
If yes, please complete the following:

Name of Employer providing other coverage _____

Employer's phone number _____

Insurance Carrier Name _____

Insurance Carrier Address _____

Insurance Carrier Phone Number _____

Type of Coverage Employer Group Health Plan Individual Policy Medicare Medicaid
 Other (please explain): _____

List all persons covered under other coverage and their coverage type under

Name (First, Mi, Last)	List Type of other coverage	Effective Date of other coverage
SPOUSE	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	/ /
CHILD	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	/ /
CHILD	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	/ /
CHILD	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	/ /
CHILD	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	/ /
CHILD	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	/ /

ACKNOWLEDGEMENT/AUTHORIZATION

I hereby apply for or decline Group Benefits(s) for which I am eligible under this Employer. In addition, I authorize my employer to reduce from each paycheck, on a pre-tax basis, the contributions shown above for benefits elected. (Note: In accordance with IRS code, some benefits may be after-tax.)

If you do not authorize your employer to reduce from each paycheck on a pre-tax basis, the contributions shown above for benefits elected, please check here:

If I participate in the Section 125 Flexible Benefit Plan, I further understand that (a) because of the pre-tax reduction in my salary, there could be a slight reduction in my social security benefits available at retirement and (b) my employer cannot be responsible for any tax liabilities which may subsequently occur as a result of my participation in the Section 125 Flexible Benefit Plan. If I participate in the voluntary products, my employer may continue to reduce on a pre or post tax basis as previously enrolled until an authorized change is made during an open enrollment period or major life event. I understand that I have the right to change my elections if (a) I experience a "major life event" such as marriage, loss of coverage, addition/deletion of dependent; or (b) the amount of premiums that I contribute during the plan year changes. **Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

Signature _____ Date _____