Open Enrollment Form 2024

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**	☐ Male ☐ 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**	☐ Active Full-Time ☐ Active Part-Time ☐ Retiree
Email Address		**Hours worked per week**	
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Never been married		
Authorized to work/reside in the United States	☐ Yes ☐ No		

REASON FOR ELECTING OR CHANGING BENEFITS

Open Enrollment Period	☐	**Status Change**	☐ Birth	☐ Spouse lost coverage under another plan
New Employee	☐		☐ Adoption	☐ Spouse changed coverage under another plan
Address Change	☐		☐ Marriage	☐ Dependent lost coverage under another plan
			☐ Divorce	☐ Other
			☐ Death	Date of event:

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		Traditional Deductible	PER PAY AMT
ELECTION			
☐	DECLINE BENEFITS		
☐	SINGLE COVERAGE	☐ $8.33/pay	
☐	EMPLOYEE + CHILD(REN) COVERAGE	☐ $16.66/pay	
☐	EMPLOYEE + SPOUSE COVERAGE	☐ $20.83/pay	
☐	FAMILY COVERAGE	☐ $25.00/pay	
			$

DENTAL BENEFITS *(benefits are available through Delta Dental and are voluntary)*			
ELECTION			
☐	DECLINE BENEFITS		
☐	SINGLE COVERAGE	☐ $7.88/pay	
☐	EMPLOYEE + 1 (spouse or one child) COVERAGE	☐ $15.24/pay	
☐	FAMILY COVERAGE	☐ $30.56/pay	$

VISION BENEFITS *(benefits are available through VSP and are voluntary)*			
ELECTION			
☐	DECLINE BENEFITS		
☐	SINGLE COVERAGE	☐ $2.58/pay	
☐	EMPLOYEE + 1 (spouse or one child) COVERAGE	☐ $3.94/pay	
☐	FAMILY COVERAGE	☐ $7.06/pay	$

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

☒ 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.*

ELECTION				
☐	DECLINE BENEFITS			
☐	EMPLOYEE COVERAGE	Minimum $10,000/Maximum $500,000 not to exceed 5x annual salary. Guaranteed Issue = $150,000	*See separate rate sheet.*	$
☐	SPOUSE COVERAGE	Minimum $10,000/Maximum $25,000 Guaranteed Issue = $25,000	*See separate rate sheet.*	$
☐	CHILD(REN) COVERAGE ***Select only one option***	Guaranteed Issue = $10,000 – *$1,000 maximum death benefit for children under 6 months.*		
	☐ Option 1 - $2,500	☐ $0.14/pay (rate is for one or multiple children)		
	☐ Option 2 - $5,000	☐ $0.28/pay (rate is for one or multiple children)		
	☐ Option 3 - $7,500	☐ $0.42/pay (rate is for one or multiple children)		
	☐ Option 4 - $10,000	☐ $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	Birth Date	Employed	Disabled	Coverage (check all that apply)			
SPOUSE		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical	☐ Dental	☐ Vision	☐ Life
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical	☐ Dental	☐ Vision	☐ Life
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical	☐ Dental	☐ Vision	☐ Life
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical	☐ Dental	☐ Vision	☐ Life
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical	☐ Dental	☐ Vision	☐ Life
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical	☐ Dental	☐ Vision	☐ Life

OTHER COVERAGE INFORMATION

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		☐ Medical ☐ Dental ☐ Vision	/ /
CHILD		☐ Medical ☐ Dental ☐ Vision	/ /
CHILD		☐ Medical ☐ Dental ☐ Vision	/ /
CHILD		☐ Medical ☐ Dental ☐ Vision	/ /
CHILD		☐ Medical ☐ Dental ☐ Vision	/ /
CHILD		☐ Medical ☐ Dental ☐ 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