

CITY OF SCOTTSDALE 2016/2017 BENEFITS ENROLLMENT/CHANGE FORM

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> Dependent change <input type="checkbox"/> Termination of Coverage	Qualifying Event: _____ Qualifying Event Date & Effective Date: _____
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FOR HUMAN RESOURCES USE ONLY		Received on:
Original to Medical File _____	Copy to Payroll on: _____	COBRA Notice Sent _____
Employee Last Name	First Name, MI	Employee ID Number
Date of Birth	Home Phone	Work Phone

MEDICAL	DENTAL	VISION
<input type="checkbox"/> CITY OF SCOTTSDALE Cigna OAP In-Network (400) <input type="checkbox"/> CITY OF SCOTTSDALE Cigna OAP (402) <input type="checkbox"/> CITY OF SCOTTSDALE Cigna OAP + HSA (404) <input type="checkbox"/> Designate Per Pay Period HSA Amount: \$ _____ (Maximum \$3,400 per year for individual, \$6,750 for family, or an additional \$1,000 if over age 55, taken over 26 pay periods) <input type="checkbox"/> WAIVE MEDICAL LEVEL OF COVERAGE Is this a level of coverage change <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Employee AND <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Child(ren) <input type="checkbox"/> Domestic Partner's Child(ren)*	<input type="checkbox"/> CITY OF SCOTTSDALE Cigna DHMO DENTAL (425) Dental Office ID# _____** <input type="checkbox"/> CITY OF SCOTTSDALE Cigna DPPO DENTAL (420) <input type="checkbox"/> WAIVE DENTAL LEVEL OF COVERAGE <input type="checkbox"/> Employee AND <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Child(ren) <input type="checkbox"/> Domestic Partner's Child(ren) * ** Dental Office ID# - The dental office you choose will be applicable for you and your dependents unless you specify a different dental office for your dependents in the dependent section of the back of this form.	<input type="checkbox"/> CITY OF SCOTTSDALE VSP (432) <input type="checkbox"/> WAIVE VISION LEVEL OF COVERAGE <input type="checkbox"/> Employee AND <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Child(ren) <input type="checkbox"/> Domestic Partner's Child(ren)*

TOBACCO SURCHARGE (462)	SHORT TERM DISABILITY (430)
Only check one box <input type="checkbox"/> I certify that neither I nor my dependent(s) have used any tobacco product including electronic cigarettes/vaporizers in the past 6 months. (\$0 month) <input type="checkbox"/> I certify that either I or my dependent(s) have used a tobacco product, including electronic cigarettes/vaporizers in the past 6 months, however, either I or my dependent(s) are currently enrolled and making progress toward a health goal in Cigna's telephonic Quit Today coaching program and therefore the \$10 per pay check surcharge will not apply. (\$0 month) <input type="checkbox"/> I certify that either I or my dependent(s) have used a tobacco product, including electronic cigarettes/vaporizers in the past 6 months, however, either I or my dependent(s) will enroll and make progress toward a health goal in Cigna's telephonic Quit Today coaching program by June 30, 2017 and therefore the \$10 per pay check surcharge will not apply. (\$0 month) <input type="checkbox"/> I certify that either I or my dependent(s) have used a tobacco product, including electronic cigarettes/vaporizers in the past 6 months, however, either I or my dependent(s) can provide a physician approved alternative/waiver and therefore the \$10 per pay check surcharge will not apply. (\$0 month) <input type="checkbox"/> None of the above scenarios apply and understand I will be charged a \$10 per pay check surcharge. (\$20 month)	<input type="checkbox"/> Waive Short Term Disability <input type="checkbox"/> 50% / week (08) <input type="checkbox"/> 70% / week (09) Short Term Disability Coverage cannot exceed 70% or \$1,000 of your weekly salary. STD can only be elected or changed during open enrollment. If you did not opt to enroll in short term disability coverage during your initial eligibility period, but opt to elect STD coverage during a future open enrollment, you will be subject to a late enrollment penalty.
HEALTHCARE FLEXIBLE SPENDING ACCOUNT (455)	
<input type="checkbox"/> NO <input type="checkbox"/> YES Designate Annual Amount \$ _____ (Maximum \$2,500 per plan year, deduction is taken 24 pay periods per year.)	
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (460)	
<input type="checkbox"/> NO <input type="checkbox"/> YES Designate Annual Amount \$ _____ (Maximum \$5,000 per plan year, deduction is taken 26 pay periods per year.)	

TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)

Spouse Name (Last, First MI)	Social Security Number	Date of Birth	Gender
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Spouse is covered on the following plan(s):

Medical	Dental, if DHMO give dependent's dental office #:	Vision
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Domestic Partner's Name* (Last, First MI)	Social Security Number	Date of Birth	Gender
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Domestic Partner is covered on the following plan(s):

Medical	Dental, if DHMO give dependent's dental office #:	Vision
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Dependent 1 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child	Gender
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Dependent 1 is covered on the following plan(s):

Medical	Dental, if DHMO give dependent's dental office #:	Vision
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Dependent 2 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child	Gender
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Dependent 2 is covered on the following plan(s):

Medical	Dental, if DHMO give dependent's dental office #:	Vision
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Dependent 3 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child	Gender
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Dependent 3 is covered on the following plan(s):

Medical	Dental, if DHMO give dependent's dental office #:	Vision
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Dependent 4 Name (Last, First MI)	Social Security Number	Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child	Gender
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Dependent 4 is covered on the following plan(s):

Medical	Dental, if DHMO give dependent's dental office #:	Vision
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Additional dependents may be listed on a separate page.

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election during the year except in the event of a life change. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that both of the flexible spending accounts must be re-enrolled in each year. I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. I authorize the City of Scottsdale to obtain any medical records regarding claims for benefits by my covered dependent(s) or me under an insurance or health plan sponsored by the City. I further authorize my health care provider to furnish the City (or its representative) any medical information concerning any claim made by my covered dependent(s) or me. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

Signature _____ Date _____

HR Signature _____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an employee to enroll a domestic partner for insurance coverage, both the employee and the domestic partner must complete the Domestic Partnership Affidavit. The affidavit must be approved by City of Scottsdale Human Resources prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the employee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the employee. City employees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 31 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 31 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 31 days will make you responsible for any premiums and claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.