5721

Group

CITY OF CHARLESTON

BENEFIT PLAN ENROLLMENT CARD

Effective Date of Coverage

_____/_____/_____

Hire Date

_____/_____/_____

Location	Dental Loc.	Department

O-Active O-Retiree O-Widow

Department

Employee Information

Name_____

(First) (Middle) (Last)

Social Security Number

Address_____

Street **City** **State** **Zip Code**

Date of Birth:_____/_____/_____

Marital Status: O-Single O-Married O-Widowed O-Divorced O-Separated

Telephone Number:_____

Sex
O Male
O Female

MEDICAL
O elect single
O elect employee + one child
O elect employee + spouse
O elect employee + children
O elect family
O do no elect coverage

DENTAL/VISION
O elect single
O elect family
O do no elect coverage

DENTAL PLAN OPTION
O Standard
O Enhanced

Names of Dependents To Be Covered:

Name	Social Security Number			Relationship	Sex M/F	Birthdate	Full Time Student Y/N	Handicapped Y/N

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Do you or any of your dependents have other health coverage? Yes No If "YES", complete the following boxes

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date/Cancel Date	Coverage Type(s)
				O Medical O Prescription Drug
				O Dental O Vision

Medicare Information - Check the appropriate boxes and fill in all information for you and dependents who are covered by Medicare.
***Check box below for each individual receiving treatment for end-stage renal disease.**

O-You	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
O-Spouse	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
O-Dependent	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease

Do any of the dependents listed above live in a different city? Y or N -- If Yes list below the dependent(s) and the city and state in which they live.

1. Dependent_____ City & State_____ 2. Dependent_____ City & State_____

_____/_____

Employee Signature Date

(Please check other side)

Healthcare Premium Discount Enrollment Verification

Overview & Instructions: The City of Charleston offers eligible full-time employees a Health Risk Management (HRM) or Non-Tobacco User (NTU) healthcare premium discount. In order to receive the HRM or NTU discount eligible employees must enroll and comply with the HRM or NTU program discount requirements. A complete description of each discount can be found in Section I. Please review each description and select the box adjacent to the premium for which you would like to enroll. If you enroll in the City's healthcare plan, **you must select one (1) box in Section I.** Complete Section II in its entirety, and sign and date the enrollment form in Section III.

Section I. Healthcare Premium Selection (Please Select only 1 Box)

☐ **Standard Rate**: Select this option if you do not want to enroll in the Health Risk Management (HRM) Program or receive the Non-Tobacco User discount.

☐ **Health Risk Management (HRM) Discount:** The City has partnered with CareHere, the operator the City of Charleston Employee Wellness Center and the Pharm UC Patient Care Clinic at the University of Charleston to offer an HRM Program to eligible employees. To participate in the HRM Program and be eligible to receive a discounted healthcare premium, you must certify and agree that you and your covered spouse, if applicable, will adhere to the program requirements including, but not limited to keeping appointments with Wellness Center and/or Pharm UC staff, complying with any program(s) prescribed by Wellness Center and/or Pharm UC medical professionals and agree to participate in random nicotine screenings.

☐ **Non-Tobacco User (NTU) Discount:** Select this option if you do not want to participate in the HRM Program, but would like to receive a reduced discounted rate for being a non-tobacco user. To participate and be eligible to receive a reduced discounted healthcare premium, you must certify that you and your covered spouse, if applicable, do not use tobacco products, and that you agree to participate in random nicotine screenings.

Section II. Employee Information (Please Print)

Name: _____ Department: _____

Section III. Certification

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge. I further understand that by enrolling in the HRM Program or electing to receive the NTU discount, by checking the designated box in Section I herein, that I agree to the applicable requirements in order to receive the associated discount. I also acknowledge and understand the City or its authorized agent may access my medical records for purposes of verifying my status as a tobacco user.

_____ _____

Employee Signature Date

C-Lect - Flexible Spending Account (FSA)

Annual Minimum $130.00 to Annual Maximum $2,600.00 Bi-weekly
per pay deduction $5.00 to $100

Employee's Name (Last, First, Middle)	Social Security Number		Date of Birth
Employee's Address	City	State	ZIP
Employee Number	Department		Date Employed

Dependent Information

Spouse's Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth

I request that my salary be reduced per pay period as follows: $

Authorization for Flexible Spending Account

Authorization: I certify the above information to be correct and true to the best of knowledge and that the children based under "Dependent Coverage" either reside with me in a parent-child relationship or are legally dependent on me for support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signature_____ Date_____