

 **ENROLL FOR ME**

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|  **2020 City of Charleston Benefit Election** |
| Location: |  | [ ]  Initial Enrollment [ ]  Open Enrollment [ ]  Status Change [ ]  Information Change Request |
| **PERSONAL INFORMATION** |
| Last Name: |  | First Name: |  | M. I. |  |
| Address: |  | City: |  | State: |  | Zip: |  |
| Birthdate: |  | Gender: |  | SSN: |  | Marital Status: |  |
| Hire Date: |  | Employment Status: | [ ]  FT [ ]  PT  | Effective Date: | Phone: |
| **DEPENDENT INFORMATION** |
| First Name | M. I. | Last Name | Relationship | Date of Birth | M/F | SSN | StudentY or N | Tobacco? | Marriage Certificate | Birth Certificate |
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| **For more information on accessing the above documents, please visit** <http://www.wvdhhr.org/bph/hsc/vital/birthcert.asp>.**Are you, your spouse, or any listed child covered by any other group health insurance?** [ ]  Yes [ ]  No**If Yes: Spousal coverage may not be available. Please refer to Spousal Carve Out provisions.** Does this Policy cover you? [ ]  Yes [ ]  NoName of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Spouse? [ ]  Yes [ ]  No Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thru: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Children? [ ]  Yes [ ]  No Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
| **FULL TIME** |
| **1. MEDICAL/ Rx**  |
| **PREMIUMS MAY CHANGE BASED ON TOBACCO USAGE** |
| Elections (24 pay periods): Employee Only Coverage: [ ]  PPB Plan A ($41.50 Per Pay Period) [ ]  PPB Plan B ($233.50 Per Pay Period) [ ]  PPB Plan C ($21.50 Per Pay Period) [ ]  PPB Plan D ($244.00 Per Pay Period) [ ]  HMO Plan A ($315.00 Per Pay Period) [ ]  HMO Plan B ($194.50 Per Pay Period)**[ ]**  **POS** ($202.50 Per Pay Period)Employee/Children Coverage: [ ]  PPB Plan A ($75.00 Per Pay Period) [ ]  PPB Plan B ($420.00 Per Pay Period) [ ]  PPB Plan C ($26.50 Per Pay Period) [ ]  PPB Plan D ($454.50 Per Pay Period) [ ]  HMO Plan A ($438.50 Per Pay Period) [ ]  HMO Plan B ($281.00 Per Pay Period)**[ ]**  **POS** ($301.50 Per Pay Period)Family Coverage: [ ]  PPB Plan A ($88.50 Per Pay Period) [ ]  PPB Plan B ($474.50 Per Pay Period) [ ]  PPB Plan C ($44.50 Per Pay Period) [ ]  PPB Plan D ($511.50 Per Pay Period) [ ]  HMO Plan A ($743.00 Per Pay Period) [ ]  HMO Plan B ($486.00 Per Pay Period)**[ ]**  **POS** ($509.00 Per Pay Period) \*Rates shown are for those that qualify for the tobacco free discount. There is $25 additional premium for single and $50 additional premium for family will be added for any employee and /or dependent who use tobacco products including includes vaping, Juuls, snuff, cigars, pipes, chew tobacco and cigarettes. |
| [ ]  **WAIVE:** I certify that I have been given the opportunity to apply for medical benefits offered by CITY OF CHARLESTON, and that after careful consideration I have decided **NOT** to take advantage of this offer. |
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| 2. HSA Election (Plan C Only) **Complete this section ONLY if you elected PPB Plan C**If you have elected the PPB Plan C you may elect to have an annual election of up to **$3,550** (single) and **$7,100** (family) deducted from your paycheck pretax\* and deposited directly in your HSA. Please complete below if you are electing this option. Amount may be less if not participating for a full 12 months.**Single** Coverage Annual Election $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cannot exceed **$2,150**, the City is contributing $1,400)**Family** Coverage Annual Election $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cannot exceed **$4,300**, the City is contributing $2,800)**$** [Annual Election Amount] **÷ 24** Paychecks **= $** Amount Per Paycheck that will be deducted.I understand this election coverage is effective July 1, 2020 through June 31, 2021.3. FSA Election (If you elect Plan C you cannot have an FSA) **Complete this section is you are electing to enroll in the FSA**If you have elected the FSA you may have an annual election of up to $2750 deducted from your paycheck pretax and deposited directly in your FSA. Please complete below if you are electing this option. **Annual FSA Election $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ]  I Do not want to fund an FSA****$** [Annual Election Amount] **÷ 24** Paychecks **= $** Amount Per Paycheck that will be deducted.I understand this election coverage is effective July 1, 2020 through June 31, 2021. |
| 4. Dependent Care FSA If you elected the Dependent Care FSA, the maximum annual contribution is **$5,000** if you are single or if you are married and filing a joint income tax return; the limit is **$2,500 per parent** if you are married and filing a separate income tax return. **Annual DFSA Election $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_****$** [Annual Election Amount] **÷ 24** Paychecks **= $** Amount Per Paycheck that will be deducted. |

I understand this election coverage is effective July 1, 2020 through June 31, 2021. |
| 5. DENTAL/VISION BENEFITS Monthly Premiums Dental / Vision Elections: Standard: [ ]  Employee ($3.40) [ ]  Employee + Spouse ($7.71) [ ]  Employee + Children ($7.71) [ ]  Family ($7.71) Enhanced: **[ ]**  Employee ($6.75) **[ ]**  Employee + Spouse ($16.08) **[ ]**  Employee + Children ($16.08) **[ ]**  Family ($16.08)  |
| [ ]  **WAIVE:** I certify that I have been given the opportunity to apply for Dental/Vision benefits offered by CITY OF CHARLESTON, and that after careful consideration I have decided **NOT** to take advantage of this offer. |
| **6. $10,000 PEIA LIFE INSURANCE Separate from current Mutual of Omaha coverage**  |
| Beneficiary Information (Percent MUST be in whole numbers). No Premium Deductions.**$10,000 Coverage under age 65, $6,500 coverage age 65-69, $5,000 coverage age 70+** |
| Primary: \_\_\_\_% Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_% Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contingent: \_\_\_\_% Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_% Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **7. PEIA VOLUNTARY LIFE INSURANCE Separate from current Mutual of Omaha coverage** **TOBACCO FREE ELECTION****TOBACCO USER ELECTION**

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| **8. PEIA DEPENDANT VOLUNTARY LIFE INSURANCE Separate from current Mutual of Omaha****Employee will automatically be the beneficiary on dependent life insurance coverage.****Life Waiver** |

**9. TOBACCO AFFADIVIT****Qualifying Events:**I authorize all providers of health care to furnish records pertaining to medical history, services rendered and treatment given as they pertain to evaluation of enrollment application and/or claims. This authorization will become effective immediately and will remain in effect as long as necessary to enable your benefits and administrator its authorized agents to process the application and/or claim.I understand that the above coverage accommodation will remain in effect until termination of my employment. I further agree to notify my employer of any changes in family status or eligibility of my spouse or dependents within the time periods indicated in the plan. Failure to notify my employer of any status change will authorize my employer to request that the benefits administrator deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.I understand that by submission of this form, coverage is not guaranteed. Coverage will be granted based on the plan provisions set forth in the Dental, Basic Life, Supplemental Life, Medical, Medical/Vision, 401K, Short-Term Disability, and Long-Term Disability plan summaries.**FRAUD WARNING STATEMENT:** **Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.**As an active employee, I authorize the deduction from my earnings of any contribution I may be required to make toward the cost of these benefits. As a Plan Member covered under the continuation provision, I agree to pay the required premiums to the employer on a timely basis.I hereby request health care coverage and/or insurance and authorize that any requested contribution for the coverage and/or insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgical Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits; and (4) any employer to provide Benefit Assistance Corporation (BAC) or its legal representative any information in its possession which is relevant to this application for coverage and/or insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees, agents and business associates of Benefit Assistance Corporation (BAC) with responsibility for (1) reviewing applications and determining eligibility for coverage and/or insurance, (2) process and/or payment of claims, and (3) any health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers or consultants, stop loss carriers, disease management service and/or wellness benefit providers or consultants, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, health plan service or any other health care operation, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). This authorization is effective on the date signed and shall remain in effect until the date such coverage and/or insurance is terminated. (You, or any individual authorized by law to act on your behalf, have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, Benefit Assistance Corporation (BAC) will be unable to process my application for coverage and/or insurance. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer at Benefit Assistance Corporation (BAC) at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to receipt of my revocation or to the extent that my coverage or a claim may be contested under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof, which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the coverage and/or insurance for me and my Dependent(s), if any.By signing this form, I certify that all the above information is complete and correct. I also certify that I have read and understand each plans eligibility and underwriting requirements.If there is a difference between the plan information shown on this form and the actual plan document, the plan document will prevail. |
| Print Name: |  | Signature: |  | Date: |  |

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| Employer Signature: |  | Signature: |  | Date: |  |

Signature above gives authorization to have all health/dental/vision elections deductions on a pre-tax basis.

**Return to the City via email: April.Thompson@CityofCharleston.org or fax 304-348-8055.**