2020 Benefits Enrollment Application/Change Request

ENROLLMENT EVENTS

EFFECTIVE DATE OF COVERAGE _____ ☐ OPEN ENROLLMENT ☐ NEW HIRE ☐ STATUS CHANGE (PT TO FT) ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE

☐ COURT ORDERED DEPENDENT ☐ OTHER (DESCRIBE)_____

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SSN

ADDRESS	APT. #	CITY	STATE	ZIP CODE

EMAIL ADDRESS	DATE OF BIRTH	GENDER	MARITAL STATUS	DATE OF HIRE	SALARY
			☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		

PRODUCT SELECTION – Check all that apply

Scott & White *Medical – Base Plan*	☐ Employee only - $0.00 per pay period ☐ Employee + Spouse - $286.20 per pay period ☐ Employee + Child(ren) - $141.64 per pay period ☐ Employee + Family - $413.64 per pay period ☐ Waive
Scott & White *Medical – Buy-Up Plan*	☐ Employee only - $18.91 per pay period ☐ Employee + Spouse - $316.00 per pay period ☐ Employee + Child(ren) - $164.19 per pay period ☐ Employee + Family - $449.85 per pay period ☐ Waive
Sun Life *Dental Plan*	☐ Employee only - $0.00 per pay period ☐ Employee + Spouse - $16.98 per pay period ☐ Employee + Child(ren) - $18.61 per pay period ☐ Employee + Family - $35.89 per pay period ☐ Waive
Dental Select *Vision Plan*	☐ Employee only - $0.00 per pay period ☐ Employee + Spouse - $1.78 per pay period ☐ Employee + Child(ren) - $1.98 per pay period ☐ Employee + Family - $3.96 per pay period ☐ Waive
Unum *Voluntary Life/AD&D Plan*	☐ Employee Only $_____ ☐ Spouse $_____ ☐ Child $_____ ☐ Waive Up to 5x Salary or $500,000 in $10,000 increments Up to 50% of EE amount or $250,000 in $5,000 increments Up to $10,000 Please see benefit guide for more details and cost of Voluntary Life/AD&D coverage.
Discovery Benefits *Flexible Spending Account (FSA)*	Annual Medical Contribution $_____ ☐ Waive 2020 Annual Maximum of $2,750 Annual Dependent Care Contribution $_____ ☐ Waive 2020 Annual Maximum of $5,000 Please see benefit guide for more details about the FSA.

*You will automatically be enrolled in Employee Basic Life/AD&D and Long Term Disability.

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FAMILY INFORMATION – List all enrolling or changing

RELATIONSHIP	LAST NAME, FIRST NAME	SSN	GENDER	DATE OF BIRTH	PRODUCT SELECTION	CHECK APPROPRIATE BOX
SPOUSE					☐ MEDICAL ☐ DENTAL ☐ VISION ☐ VOL. LIFE	☐ ENROLL ☐ CANCEL ☐ CHANGE
DEPENDENT					☐ MEDICAL ☐ DENTAL ☐ VISION ☐ VOL. LIFE	☐ ENROLL ☐ CANCEL ☐ CHANGE
DEPENDENT					☐ MEDICAL ☐ DENTAL ☐ VISION ☐ VOL. LIFE	☐ ENROLL ☐ CANCEL ☐ CHANGE
DEPENDENT					☐ MEDICAL ☐ DENTAL ☐ VISION ☐ VOL. LIFE	☐ ENROLL ☐ CANCEL ☐ CHANGE
DEPENDENT					☐ MEDICAL ☐ DENTAL ☐ VISION ☐ VOL. LIFE	☐ ENROLL ☐ CANCEL ☐ CHANGE
DEPENDENT					☐ MEDICAL ☐ DENTAL ☐ VISION ☐ VOL. LIFE	☐ ENROLL ☐ CANCEL ☐ CHANGE

REASON FOR WAIVING MEDICAL COVERAGE

☐ OTHER GROUP MEDICAL COVERAGE (for example-covered under spouse's employer's plan) ☐ OTHER INDIVDIUAL MEDICAL COVERAGE ☐ NOT COVERED – WAIVING DUE TO COST
☐ MEDICARE ☐ MEDICAID ☐ OTHER (Explain) ____

BASIC AND VOLUNTARY LIFE INSURANCE BENEFICIARY INFORMATION

NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	SSN	%	CHECK APPROPRIATE BOX
					_____%	☐ Primary ☐ Secondary
					_____%	☐ Primary ☐ Secondary
					_____%	☐ Primary ☐ Secondary
					_____%	☐ Primary ☐ Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number and full address. I) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee Life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary survives you. The proceeds will be paid in equal shares to the surviving secondary beneficiaries.

SIGNATURE

I give The City of Taylor consent to withhold my Medical, Dental, and Vision premiums on a pre-tax basis. I confirm that the information I have provided on this form is complete and accurate. If waiving any coverage, I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying life event, at the next open enrollment period, or as a late enrollee, if applicable.

DATE:	EMPLOYEE SIGNATURE :