City of Austin
2012 Benefits Enrollment Form

FOR OFFICE USE ONLY	Effective Date
MEDICAL	
ALL OTHER BENEFITS	

☐ NEW ENROLLMENT ☐ CHANGE WITHIN 31 DAYS ☐ DROP DEPENDENTS ☐ LOA END
☐ OPEN ENROLLMENT ☐ WORK STATUS CHANGE ☐ COURT ORDER ☐ CHANGE ADDRESS/NAME
☐ CANCEL COVERAGE ☐ ADD DEPENDENTS ☐ LOA BEGIN ☐ OTHER
☐ RETURNING RETIREE WITH COA RETIREE BENEFITS - complete retiree form

REASON FOR CHANGE:_____

A: EMPLOYEE DATA

SOC SEC NO	LAST NAME	FIRST NAME	MIDDLE NAME
ADDRESS		CITY	STATE / ZIP CODE
COUNTY	HOME PHONE	WORK PHONE	DEPARTMENT

☐ FT 30 > HRS ☐ PT 20 - 29 HRS ☐ PT < 20 HRS | CIVIL SERVICE ☐ YES ☐ NO | ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER | BIRTHDATE

What is your primary language if not English? ☐ YES ☐ NO Do you have a disability that affects your ability to communicate or read? If yes, please indicate the nature of your disability.

B: FLEXTRA

FLEXTRA participation is for the entire year except within 31 days of an IRS permitted change. Money not claimed by the deadline will be forfeited.

FLEXTRA Health Care (FHC) Pay Period Maximum $250 ☐ YES $_____ Pay Period Amount ☐ NO
One FLEXTRA Benefits Card will be provided at no cost if you enroll in FHC.

FLEXTRA Dependent Care (FDC) Pay Period Maximum $208 ☐ YES $_____ Pay Period Amount ☐ NO

C: COVERAGE INFORMATION

MEDICAL **UnitedHealthcare** (Group No. 704244) ☐ Employee Only ☐ Employee & Spouse/Domestic Partner ☐ Employee & Children
☐ **Choice Plus PPO** ☐ **Choice HMO** ☐ Employee & Family/Domestic Partner & Children ☐ Waive (Full-time employees complete Waiver form)

DENTAL **Dental Assistance Plan** (Group No. 100) ☐ Employee Only ☐ Employee & Spouse/Domestic Partner ☐ Employee & Children
☐ Employee & Family/Domestic Partner & Children ☐ Waive (Full-time employees complete Waiver form)

VISION **Davis Vision** (Group No. X66) ☐ Employee Only ☐ Employee & Spouse/Domestic Partner ☐ Employee & Children
☐ Employee & Family/Domestic Partner & Children ☐ Waive

LIFE **Basic** ☐ 1X Base Annual Salary ☐ Capped at $50,000 (Base annual salary must be $50,000 or higher) ☐ Waive
Supplemental Pre-tax Premiums ☐ YES ☐ NO **Amounts** ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ Waive
Dependent ☐ **Opt. 1: $10,000/$5,000** ☐ **Opt. 2: $20,000/$10,000** ☐ Spouse/Domestic Partner ☐ Children ☐ Family/Domestic Partner & Children ☐ Waive

DISABILITY **Short Term** Employees scheduled to work 20+ hrs per week are enrolled for STD at no cost. **Long Term** ☐ YES ☐ Waive

PREPAID LEGAL Group No. (1998-100) ☐ Employee Only ☐ Employee & Family/Domestic Partner & Children ☐ Waive

OTHER COVERAGE: If you or your dependents listed in Section D have other medical or dental coverage, complete the following:

Insurance Co/Medicare:_____ Policyholder:_____ Policy No:_____

Insurance Co/Medicare:_____ Policyholder:_____ Policy No:_____

D: DEPENDENT DATA

Name (Last, First, Middle)	Marriage Date / / (mm dd yy)	Social Security Number	Child Married Y/N	Relation Abrev.	Biological Child Y/N	Birthdate mm/dd/yy	Sex M/F	FHC Y/N	FDC Y/N	Med Y/N	Den Y/N	Vision Y/N	Life Y/N	Legal Y/N	IRS Dep Y/N	Add (A) Drop (D)

E: CONTRACT/ AUTHORIZATION

I certify that I have read the terms and conditions on the back of this form. I understand, acknowledge, and accept them.

SIGNATURE _____ DATE _____

08/11

White—File; Pink—TPA; Gold– Employee

CONTRACT AGREEMENT AND PAYROLL AUTHORIZATION

I certify that the information I have provided is true and correct and that I have not withheld information on this application. I am aware that any misrepresentation may lead to my dismissal or may cause my application to be rejected. I agree to comply with the rules set forth in the plan document(s) and/or insurance contract(s) for the plans offered by the City. I further authorize any physician and/or medical facility to release information about the health condition or treatment of myself or any dependent enrolled in the plan(s) to the Contractor(s) upon request as necessary to determine what will be paid and to process the claim. **I authorize the appropriate payroll deductions and/or salary reduction (FLEXTRA) for the coverage requested, beginning on the effective date indicated and continuing in future plan years, as long as such coverage is offered, or until I terminate employment or request a change by submitting a new Benefits Enrollment Form and all required documentation.** I understand that FLEXTRA elections cannot be changed during the plan year, except within 31 days of an IRS permitted change. I certify that the dependent(s) listed in section D are eligible dependent(s) as defined in the plan document(s). For each individual who is not a dependent for Federal income tax purposes, additional income will be reported to the IRS and applicable taxes withheld on the premium cost. I agree that I am responsible for paying health care expenses incurred by each person for whom I am buying coverage, and I agree to reimburse any incorrect benefits payments made directly to me. I understand that the City has the right to collect contributions owed. Conversely I will be reimbursed if an overpayment occurs; however, the City will only reimburse for up to 31 days of premiums. Further, I understand that the City is not in any way acting as an agent for the prepaid legal plan I selected or for me, and I agree not to assert at any time that the City is an agent for either party. In addition, I hereby release the City from any liability that might be asserted against it in connection with its duties under this authorization.

INSTRUCTIONS FOR COMPLETING THE BENEFITS ENROLLMENT FORM

REASON FOR CHANGE - Indicate the reason for changing coverage.

A: EMPLOYEE DATA - Complete all the information requested.

B: FLEXTRA - If you choose to participate in the Health Care and/or Dependent Care Account(s), indicate your choices by darkening the appropriate boxes. You must also indicate the amount you wish to have deducted each pay period for the Health Care and/or Dependent Care Account(s) if you choose to participate in either account. If you participate in the FLEXTRA Health Care Account, one FLEXTRA Benefits Card will be provided at no cost. If you choose to participate in the Dependent Care Account, you must complete a Dependent Care Certificate and attach it to your Benefits Enrollment Form.

C: COVERAGE INFORMATION
MEDICAL - Darken one box under Medical to indicate your choice of UnitedHealthcare PPO or UnitedHealthCare HMO, or Waive Coverage. If you are a full-time, regular employee and you choose to decline medical coverage offered by the City of Austin, you must also complete a Waiver to Decline Medical and/or Dental Coverage Form and provide proof of other coverage. Darken one box to indicate your level of coverage. **If adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form. You may not enroll children of your domestic partner without adding the domestic partner. Darken one box to indicate your coverage level.**

DENTAL - Darken one box to indicate your level of coverage. If you are a full-time, regular employee and you choose to decline dental coverage offered by the City of Austin, you must also complete a Waiver to Decline Medical and/or Dental Coverage Form and provide proof of other coverage. **If adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form. You may not enroll children of your domestic partner without adding the domestic partner. Darken one box to indicate your coverage level.**

VISION - Darken one box to indicate your coverage level. **If adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form. You may not enroll children of your domestic partner without adding the domestic partner. Darken one box to indicate your coverage level.**

LIFE - **Basic Life-**Darken one box to indicate your choice for Basic Life insurance for yourself. (Regular employees scheduled to work 30 or more hours per week, must enroll for Basic Life—provided at no cost to you.) The City offers two options for Basic Life Insurance; Coverage at one times your base annual salary; or you may cap your coverage at $50,000 if your earned income is greater than $50,000. **Supplemental Life**-Darken one box to indicate if you would like eligible premiums deducted on a pre-tax basis and one to indicate your choice for the annual salary coverage amount. **Dependent Life**- Darken one box in Option 1 or Option 2 to indicate your volume of coverage. Darken one box to indicate your level of coverage. **You may not enroll children of your domestic partner without adding the domestic partner. Darken one box to indicate your coverage level.**

DISABILITY - Darken one box to indicate your choice for Long Term Disability.

PREPAID LEGAL - Darken one box to indicate your coverage level. If **adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form.**

OTHER COVERAGE - Complete this section only if you or your covered dependents have other medical and/or dental coverage or Medicare in addition to the coverage selected on this form.

D: DEPENDENT DATA - Complete this section if any of your choices in Section B and C include coverage for your dependents. List each dependent and complete each box on the rows where you have written a dependent's name. Use the first line for your spouse or domestic partner's data, if applicable. Remember to include your date of marriage, if applicable.

For IRS dependent, indicate whether this person qualifies as a dependent on your Federal income tax return by writing "Y" for YES or "N" for NO. The instructions for Form 1040 or 1040A (available through the IRS) explain who is an eligible IRS dependent. Your spouse is always considered an IRS dependent even though you may be filing separate tax returns.For each new dependent you are enrolling (currently not covered for benefits), write Add in the last column. To drop coverage for a dependent you currently cover, write Drop in the last column.

If you have more than five dependents, you will need to complete two Benefits Enrollment Forms. On the first form, complete all sections. On the second form, complete your name and Social Security number in Section A and complete Section D for additional dependents. Sign and date both forms and attach the second form to the first.

E: CONTRACT/AUTHORIZATION - Read the CONTRACT AGREEMENT AND PAYROLL AUTHORIZATION statement at the top of this page. After reading the statement, be sure to sign and date the front of this form. **Your benefits choices cannot become effective if your form is not signed and dated.**