HICKORY North Carolina

Life. Well Crafted.

BENEFITS ENROLLMENT / CHANGE FORM

PART A PLEASE CIRCLE:

Legal Marital Status: Married Not Married Race: Sex: Male Female Date of Birth: Employment Date:

Name: LAST FIRST MI FORMER LAST NAME (IF CHANGED) SOCIAL SECURITY NUMBER

Address: STREET OR P.O. BOX CITY STATE ZIP CODE TELEPHONE EMAIL ADDRESS

MEDICAL INSURANCE COVERAGE PPO HSA I Decline Coverage No Change

Please choose one of the following: Employee only Employee & Child Employee & Children

Will you or your dependents be covered under other health insurance on he effective date of this coverage? NO YES

List Coverage

PART C

DENTAL COVERAGE	Employee only	Spouse	Child	Children	Family	I Decline Coverage	No Change
VISION COVERAGE	Employee only	Spouse		Children	Family	I Decline Coverage	No Change

PART D Dependents-Complete in Full - List any additional dependents on the back of this form.

ADD DELETE	LAST NAME	FIRST NAME	MI	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVERAGE
ADD DELETE								Medical Dental Vision
ADD DELETE								Medical Dental Vision
ADD DELETE								Medical Dental Vision
ADD DELETE								Medical Dental Vision
ADD DELETE								Medical Dental Vision
ADD DELETE								Medical Dental Vision

OVER →

PART E **BENEFICIARY DESIGNATION** - BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE* **(City Provided)**

NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ADDRESS	BENEFICIARY DESIGNATION	
						PRIMARY	CONTINGENT
						PRIMARY	CONTINGENT
						PRIMARY	CONTINGENT
						PRIMARY	CONTINGENT
						PRIMARY	CONTINGENT

*IMPORTANT: Please list your beneficiaries for your Basic Life and AD&D insurance. (City provided) Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. (If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise.)

PART F **OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE** I Elect coverage I Decline coverage No Change

Employee Paid - Submit within 31 days of hire or medical statement required Amount: $25,000 $50,000 $75,000 $100,000

Beneficiaries will be the same for Part E and Part F, unless designated separately.

PART G **DEPENDENT OPTIONAL LIFE INSURANCE** - List Dependent information in Part D

I Elect Coverage (Additional form required) I Decline Coverage No Change

OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE

I Elect coverage (Additional form required) I Decline Coverage No Change

Dependents

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	RELATIONSHIP

PART H **MEDICAL INSURANCE PLAN CHANGE** Date of Change:

Open Enrollment PPO Dental
HSA with contribution Vision
HSA without contribution

DEPENDENT COVERAGE CHANGES Date of change:

Reason for change:

Marriage Newly eligible for coverage Dependent died
Spouse's Coverage terminated Child reached age limit Divorce
Other, specify _____ No longer a student Birth/Adoption

PART I *******I understand this is a legal binding document and I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will remain in effect until revoked in writing. Medical, vision and dental insurance deduction is paid on a pre-tax basis unless a waiver is submitted.***

Employee Signature **Date**

****FOR OFFICE USE:** HEALTH DENTAL VISION LIFE/AD&D OPTIONAL LIFE/AD&D Salary Min Hours worked