



# 2021 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
EMAIL ADDRESS		DATE OF BIRTH	GENDER	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		DATE OF HIRE
						Phone Number

## PRODUCT SELECTION – Check all that apply

Scott & White <i>Medical – Base Plan</i>	<input type="checkbox"/> Employee only - \$0.00 per pay period <input type="checkbox"/> Employee + Spouse - \$293.58 per pay period <input type="checkbox"/> Employee + Child(ren) - 145.29 per pay period <input type="checkbox"/> Employee + Family - \$424.32 per pay period <input type="checkbox"/> Waive
Scott & White <i>Medical – Buy-Up Plan</i>	<input type="checkbox"/> Employee only - \$19.40 per pay period <input type="checkbox"/> Employee + Spouse - \$324.15 per pay period <input type="checkbox"/> Employee + Child(ren) - \$168.42 per pay period <input type="checkbox"/> Employee + Family - \$461.46 per pay period <input type="checkbox"/> Waive
Sun Life <i>Dental Plan</i>	<input type="checkbox"/> Employee only - \$0.00 per pay period <input type="checkbox"/> Employee + Spouse - \$16.68 per pay period <input type="checkbox"/> Employee + Child(ren) - \$18.27 per pay period <input type="checkbox"/> Employee + Family - \$35.25 per pay period <input type="checkbox"/> Waive
Dental Select <i>Vision Plan</i>	<input type="checkbox"/> Employee only - \$0.00 per pay period <input type="checkbox"/> Employee + Spouse - \$1.78 per pay period <input type="checkbox"/> Employee + Child(ren) - \$1.98 per pay period <input type="checkbox"/> Employee + Family - \$3.96 per pay period <input type="checkbox"/> Waive
Unum <i>Voluntary Life/AD&amp;D Plan</i>	<input type="checkbox"/> Employee Only \$ _____ <input type="checkbox"/> Spouse \$ _____ <input type="checkbox"/> Child \$ _____ <input type="checkbox"/> 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 <i>Flexible Spending Account (FSA)</i>	Annual Medical Contribution \$ _____ <input type="checkbox"/> Waive 2020 Annual Maximum of \$2,750 Annual Dependent Care Contribution \$ _____ <input type="checkbox"/> Waive 2020 Annual Maximum of \$5,000 Driver License # _____ Issue Date: _____ Expiration Date: _____ 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					<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> VOL. LIFE	<input type="checkbox"/> ENROLL <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE
DEPENDENT					<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> VOL. LIFE	<input type="checkbox"/> ENROLL <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE
DEPENDENT					<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> VOL. LIFE	<input type="checkbox"/> ENROLL <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE
DEPENDENT					<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> VOL. LIFE	<input type="checkbox"/> ENROLL <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE
DEPENDENT					<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> VOL. LIFE	<input type="checkbox"/> ENROLL <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE
DEPENDENT					<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> VOL. LIFE	<input type="checkbox"/> ENROLL <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE

## REASON FOR WAIVING MEDICAL COVERAGE

OTHER GROUP MEDICAL COVERAGE (for example-covered under spouse's employer's plan)   
  OTHER INDIVIDUAL 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
					____%	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
					____%	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
					____%	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
					____%	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number and full address. 1) 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 :
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