



FY20 BENEFIT ENROLLMENT FORM

<input type="checkbox"/> New Hire: _____ (Hire Date)	Employee ID:	Effective Date (For HR USE ONLY):
	Department:	
<input type="checkbox"/> Change: _____ Attach Supporting Documents (Reason) (Date of Event)	Cell Phone:	Personal Email:
<input type="checkbox"/> Open Enrollment: _____	Legal First Name:	Legal Last Name:

BENEFIT ELECTIONS – EMPLOYEE MONTHLY COSTS

EE= Employee Only		EE1= Employee + 1	EE Fam= Employee + Family	
MEDICAL PLAN (BCBSAZ Administered)		DENTAL PLAN (DELTA DENTAL)	VISION PLAN (AVESIS)	
Alliance EPO <input type="checkbox"/> EE.....\$52.00 <input type="checkbox"/> EE1.....\$196.00 <input type="checkbox"/> EE Fam..\$308.00	HMO <input type="checkbox"/> EE.....\$65.00 <input type="checkbox"/> EE1.....\$245.00 <input type="checkbox"/> EE Fam..\$385.00	PPO <input type="checkbox"/> EE.....\$65.00 <input type="checkbox"/> EE1.....\$245.00 <input type="checkbox"/> EE Fam..\$385.00	PPO Plus Premier <input type="checkbox"/> EE.....\$5.18 <input type="checkbox"/> EE1.....\$17.62 <input type="checkbox"/> EE Fam..\$37.06 <input type="checkbox"/> Decline	PPO <input type="checkbox"/> EE.....\$1.00 <input type="checkbox"/> EE Fam..\$3.76 <input type="checkbox"/> Decline
<input type="checkbox"/> Decline. I was offered minimum essential coverage (MEC) and I am declining. <input type="checkbox"/> Coordination: I and/or my dependents have secondary medical insurance.				<input type="checkbox"/> Dependent coverage..\$3.04 (Coverage = \$5,000/Child & \$10,000/Spouse) Children up to age 26 Additional form needed <input type="checkbox"/> Decline (dependent coverage) <input checked="" type="checkbox"/> BASIC.....\$0.00 (Coverage = 2x Salary FTR or Flat \$200k Elected Off.) Additional form needed for new hires only

ADDITIONAL LIFE (STANDARD) ¹			Pension Plan (ASRS/PSPRS)	65+ ASRS Waiver (ASRS)
<input type="checkbox"/> EMPLOYEE \$ _____ Coverage over \$120,000 or 3x annual salary (lesser supersedes), requires a Statement of Health Form. Max coverage allowed \$500,000 or 5x annual salary (lesser supersedes). Additional form needed <input type="checkbox"/> Decline	<input type="checkbox"/> SPOUSE \$ _____ Coverage over \$40,000 requires a Statement of Health Form. Max coverage allowed \$100,000. Coverage cannot exceed 100% of employee voluntary life election. Additional form needed <input type="checkbox"/> Decline	<input type="checkbox"/> DEPENDENT(S) Cost: \$3.44 Coverage Amount: \$25,000 for up to age 26. Employee must enroll in minimum \$30,000 coverage for self. Additional form needed <input type="checkbox"/> Decline	I am retired with PSPRS <input type="checkbox"/> Yes <input type="checkbox"/> No I am retired with ASRS <input type="checkbox"/> Yes <input type="checkbox"/> No	I am age 65 or older and have never contributed to ASRS. <input type="checkbox"/> Yes <input type="checkbox"/> No Are you within 30 days of initial hire with the City of Surprise and wish to waive membership to ASRS? <input type="checkbox"/> Yes Additional form needed <input type="checkbox"/> No

SUPPLEMENTAL RETIREMENT (NATIONWIDE)	FLEXIBLE SAVINGS ACCOUNT (Health Equity)		SUPPLEMENTAL COVERAGE (AFLAC)
457(b) NRSFORU.com <input type="checkbox"/> Completed enrollment form New Hires only 401(a) Nationwide/ASRS² <input type="checkbox"/> % _____ \$ _____ (1% minimum) OR (\$10 minimum) Additional form needed <input type="checkbox"/> Decline 401(a)	Medical Expense Election³ <input type="checkbox"/> Elect (new election required each FY) \$100 Min/\$2,700 Annual Max (07/01-06/30) Amount Per Pay Period: \$ _____ Annual Election (# of Pay periods remaining X per pay period contribution): \$ _____ <input type="checkbox"/> Decline	Dependent Care Election³ <input type="checkbox"/> Elect (new election required each FY) \$100 Min/\$5,000 Annual Max (07/01-06/30) Amount Per Pay Period: \$ _____ Annual Election (# of Pay periods remaining X per pay period contribution): \$ _____ <input type="checkbox"/> Decline	<input type="checkbox"/> Specified Health Event <input type="checkbox"/> Cancer Indemnity <input type="checkbox"/> Accident Indemnity <input type="checkbox"/> Hospital Indemnity *Note coverage is not guaranteed & is subject to approval by AFLAC. Additional form needed <input type="checkbox"/> Decline

DEPENDENT INFORMATION (For EE1 and EE Fam plans, list all dependents, type of coverage and action requested.)

Legal Name (Last, First, MI)	Relationship SP=Spouse CH=Child DP=Domestic Partner ⁴ DPC= Domestic Partner's Child	Date of Birth	Sex M/F	Social Security Number REQUIRED	Add or Remove Dependents A=Add R=Remove NC= No Change				
					Medical	Dental	Vision	Group Life	Additional Life

¹Coverage is not guaranteed & subject to approval by Standard. If coverage is not elected at initial offer statement of health is required.

²Must be Fulltime Regular Employee within 2 years of your date of hire and at least 30 years of age at time of enrollment.

³Medical and Dependent Care Flexible Savings Account (FSA) maximums are set per individual/household by the IRS each calendar year. Please go to www.irs.gov to determine if you are within your annual maximum limit. The City of Surprise does not track your contributions with other FSA plans.

⁴Must submit Domestic Partnership Affidavit form, supporting documentation and Certification of Domestic Partner Tax Status. Benefits available for health, dental and vision coverage only.

I hereby apply for group benefits for which I am eligible under the City of Surprise group plan(s) and authorize that the appropriate payroll deductions, if required, be deducted from my earnings. I have carefully read all the forms & been given information that explains the terms & conditions of this coverage. On behalf of myself & the person(s) listed as eligible dependent(s) on the enrollment form(s), I apply for enrollment and/or waive group benefits subject to all terms and conditions of each carrier offered by my employer. **I understand I must submit a Public Benefit Dependent Affidavit with supporting documentation for my added dependent(s) within 90 days of their benefit effective date or they will be disenrolled from coverage.**

Signature: _____	Date: _____
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HR USE ONLY

Forms Collected/Completed		Data Entry	
_____ HIPAA Notice of Privacy Practices	_____ Standard basic/Additional life form	_____ MUNIS	_____ Email 457 EZ Enrollment to Nationwide
_____ Public Dependent Affidavit (if applicable)	_____ 457 Nationwide EZ Enrollment Form	_____ COBRA Solutions (initial notice)	_____ Email PEHP form to Nationwide (if applicable)
_____ Documents for Affidavit (if applicable)	_____ Domestic Partner forms (if applicable)	_____ Laserfiche	_____ Email PSPRS forms to PSPRS (if applicable)
_____ Marriage Certificate (if applicable)			_____ Follow-up on AFLAC enrollment (if applicable)
_____ ASRS Enroll online or PSPRS form			_____ Follow-up on Additional Life SOH (if applicable)