FY21 BENEFIT ENROLLMENT FORM

☐New Hire: ______ (Hire Date) ☐Change: ______ ______ Attach Supporting Documents (Reason) (Date of Event) ☐Open Enrollment: ______	Employee ID: Department:	Effective Date (**For HR USE ONLY)**:
	Cell Phone:	Personal Email:
Legal First Name:	MI:	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)	GROUP LIFE (STANDARD) [1]
Alliance EPO ☐EE..........$52.00 ☐EE1........$196.00 ☐EE Fam..$308.00	**HMO** ☐EE..........$65.00 ☐EE1........$245.00 ☐EE Fam..$385.00	**PPO** ☐EE.........$65.00 ☐EE1........$245.00 ☐EE Fam..$385.00	**PPO Plus Premier** ☐EE..........$5.18 ☐EE1........$17.62 ☐EE Fam..$37.06 ☐ Decline	**PPO** ☐EE..........$1.00 ☐EE Fam..$3.76 ☐ Decline	☐Dependent coverage..$3.04 (Coverage = $5,000/Child & $10,000/Spouse) Children up to age 26 Additional form needed ☐ Decline (dependent coverage) ☒BASIC..........$0.00 (Coverage = 2x Salary FTR or Flat $200k Elected Off.) Additional form needed for new hires only
☐**Decline**. I was offered minimum essential coverage (MEC) and I am declining. ☐**Coordination:** I and/or my dependents have secondary medical insurance.					

ADDITIONAL LIFE (STANDARD) [1]			Pension Plan (ASRS/PSPRS)	65+ ASRS Waiver (ASRS)
☐**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 ☐ Decline	☐**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 ☐ Decline	☐**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 ☐ Decline	I am retired with PSPRS ☐Yes ☐No I am retired with ASRS ☐Yes ☐No	I am age 65 or older and have never contributed to ASRS. ☐Yes ☐No Are you within 30 days of initial hire with the City of Surprise and wish to waive membership to ASRS? ☐Yes Additional form needed ☐No

SUPPLEMENTAL RETIREMENT (NATIONWIDE)	FLEXIBLE SAVINGS ACCOUNT (Health Equity)		SUPPLEMENTAL COVERAGE (AFLAC)
457(b) NRSFORU.com ☐Completed enrollment form **New Hires only** **401(a) Nationwide/ASRS[2]** ☐%______ $______ (1% minimum) **OR** ($10 minimum) Additional form needed ☐ Decline 401(a)	**Medical Expense Election [3]** ☐Elect (new election required each FY) $100 Min/$2,750 Annual Max (07/01-06/30) **Amount Per Pay Period**: $______ **Annual Election** (# of Pay periods remaining X per pay period contribution): $______ ☐ Decline	**Dependent Care Election [3]** ☐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): $______ ☐ Decline	☐Specified Health Event ☐Cancer Indemnity ☐Accident Indemnity ☐Hospital Indemnity *Note coverage is not guaranteed & is subject to approval by AFLAC. Additional form needed ☐ Decline

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

Legal Name (Last, First, MI)	Relationship[4] **SP**=Spouse **CH**=Child **DP**=Domestic Partner[5] **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

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

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

[3]Medical 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.

[4]Per the City of Surprise plan documents a dependent is defined as:
- the Contract holder's spouse under a legally valid existing marriage. Must submit a marriage certificate evidencing the legally valid existing marriage.
- the Contract holder's children or the children of the Contract holder's spouse (up to the age of 26), including birth children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order
- the Contract holder's domestic partner and the children of the Contract holder's domestic partner (up to the age of 26)

[5]Must 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 (i.e., Benefit Guide, plan documents, affidavits, etc). 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. Furthermore, I understand that I have 31 days to notify HR if a dependent becomes ineligible and if I fail to do so, then I am responsible for any costs incurred by the City for claims and employer premiums after the dependent became ineligible.**

Signature:	Date: