Benefits Enrollment Form

2020 Plan Year

PLEASE PRINT *LEGIBLY* AND COMPLETE HIGHLIGHTED INFORMATION REQUESTED UNLESS YOU ARE A NEW ENROLLEE. NEW ENROLLEES MUST COMPLETE ALL BOXES. For Medical, Dental, Vision, HSA, FSA check box to elect (& appropriate dependent tier if applicable), Waive or Continue Coverage - No Change (N/C).

Employee Name (Last, First, MI)		**Social Security Number**	**Date of Birth**
Work Phone and extension ( )	**Home Phone** ( )	**Address (Mailing)**	
City, State, Zip Code		**Home or Personal Email Address**	
Marital Status ☐Single ☐ Married	**Gender**	**Date of Hire**	**Effective Date for Benefits to Begin**

Type of Enrollment (check one) ☐Add Dependent(s) ☐Common Law Marriage ☐Other_____
☐New Hire ☐ Drop Dependent(s) ☐Domestic Partner ☐Open Enrollment

Qualifying Event (check one) ☐Birth ☐Marriage ☐Loss of Coverage
☐New Hire ☐Other Insurance ☐Divorce ☐Open Enrollment

PRE-TAX Premium ELECTION (check one)

Elect or Waive

☐ I authorize the City to deduct my medical and/or vision, dental and voluntary benefits on a pre-tax basis
☐ I choose to not have my medical and/or vision, dental and voluntary benefits on a pre-tax basis
☐ I was offered affordable Minimum Value Essential Health Benefits medical coverage by the City and because I have other medical coverage, **I am waiving my enrollment in the medical coverage offered.**

DENTAL PLAN (check one)

(Elect & Choose Dependent Coverage or select Waive)
☐ CONTINUE Coverage – N/C
☐ I Will WAIVE Dental Coverage
☐ I Elect Delta Dental

(Select Coverage Option)
☐ Employee Only
☐ Employee + Plus One
☐ Employee + Children
☐ Employee + Family

VISION PLAN (check one)

(Elect & Choose Dependent Coverage or select Waive)
☐ CONTINUE Coverage – N/C
☐ I WILL WAIVE Vision Coverage
☐I Elect VSP Vision

(Select Coverage Option)
☐ Employee Only
☐ Employee + Plus One
☐ Employee + Children
☐ Employee + Family

MEDICAL PLANS – YOU MUST SELECT ONE MEDICAL PLAN OPTION OR WAIVE!

Classic - OAPN1	Tiered Hospital - OAP1	HDHPQ – OAP2
☐ CONTINUE Coverage – N/C	☐ CONTINUE Coverage – N/C	☐ CONTINUE Coverage – N/C
☐ I Will WAIVE Medical Coverage	☐ I Will WAIVE Medical Coverage	☐ I Will WAIVE Medical Coverage
☐ I Elect Cigna Medical	☐ I Elect Cigna Medical	☐ I Elect Cigna Medical
☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee + One	☐ Employee + One	☐ Employee + One
☐ Employee + 2 or more	☐Employee + 2 or more	☐Employee + 2 or more

If there are no changes to your dependent(s) status or information you do not need to complete the below information. Please check only dependents you wish to add or modify existing coverages on.

	Last Name, First Name, MI	Date of Birth	Social Security No.	Sex	Benefit Election (Check all that apply)
Spouse: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision
Dependent: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision

Dependent: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision
Dependent: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision
Dependent: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision
Dependent: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision
Dependent: ☐ Add ☐Remove				☐M ☐F	☐Medical ☐Dental ☐Vision

(check if applicable)

☐ **I waived health coverage** through the City of Grand Junction **and would like to participate in the Wellness Challenges offered by the City**. Please setup a "Tech Only Account" with the Sage Health and Wellness Center powered by Marathon Health.

HEALTH SAVINGS ACCOUNT (HSA) – if electing HSA Medical Plan through Home Loan

Please certify below by checking the box and elect the coverage type by selecting the box next to the corresponding coverage type and enter the election amount or waive HSA.

☐I certify that I am eligible to contribute to an HSA and my annual contribution will not exceed the amount permitted. I also certify the purpose and funds for this account are for a Health Savings Account (HSA)

Coverage - 1/1/20 – 12/31/20 - (check one)	**Annual Election Amount (Pre-Tax)**	**Per Pay Period Amount (26 Pay Periods)**
☐Single ($3,550-$750=**$2,800**= Max)	$	$
☐Family ($7,100-$1,500=**$5,500** Max)	$	$
☐Catchup 2020 (**$1,000** if age 55-65)	$	$
☐WAIVE HSA or NOT ELIGIBLE TO ELECT		

FLEXIBLE SPENDING ACCOUNT (FSA) – if electing Pre-Tax FSA Medical, Dental and Vision Election

Please certify below by checking the box and elect the coverage type by selecting the box next to the corresponding coverage type and enter the election amount or waive FSA.

☐I certify that I am eligible to contribute to an FSA and my annual contribution will not exceed the amount permitted. I also certify the purpose and funds for this account are for Qualified Medical, Dental and Vision expenses.

Coverage - 1/1/20 – 03/15/21 (check one)	**Annual Election Amount**	**Per Pay Period Amount (26 Pay Periods)**
☐Single Coverage (**$2,750** Max)	$	$
☐Family Coverage (**$5,000** Max)	$	$
☐WAIVE FSA or NOT ELIGIBLE TO ELECT		

DEPENDENT CARE ACCOUNT

Maximum of $5,000 if single or married filing jointly. Maximum of $2,500 if married filing separately. Reimburse child or elder care expenses incurred by a qualified dependent from 1/1/2020 to 12/31/2020.

Coverage (check one)	**Annual Election Amount**	**Per Pay Period Amount (26 Pay Periods)**
☐Single Coverage (**$2,500** Max)	$	$
☐Family Coverage (**$5,000** Max)	$	$
☐WAIVE FSA or NOT ELIGIBLE TO ELECT		

Employee Signature: ____ **Date:** ___________________________

Print Employee Name Legibly: ____

HR Payroll ________________________