

Medical, Dental and Vision Insurance Enrollment Form*

Employee Information: (Please print)

Last Name First Name Employee # or Birth Date (mm/dd/yyyy) last 4-digits of SSN

Enrollment Status *: (Please check one)

New Hire	Change Coverage
New Hire (Temporary Benefits Eligible - TBE)	Name Change Only
	,

^{*}Also used for changes within 30-day enrollment period and qualifying events (e.g. moving out of service area, union plan change)

Coverage Options:

Medical (Please select <u>one</u> medical option below)	Dependent Options (with or without children)	Employee Premium Share		
Astro Decembra Disc	Employee Only	\$48.12		
Aetna Preventive Plan	Employee & Spouse/Domestic Partner	\$98.50		
Aetna Traditional Plan	Employee Only	\$0.00		
Actia Traditional Flair	Employee & Spouse/Domestic Partner	\$32.34		
	Employee Only	\$48.40		
Kaiser Permanente Standard Plan	Employee & Spouse/Domestic Partner	\$99.90		
	Employee & Spouse, Domestier at the	-		
Kaiser Permanente Deductible Plan	Employee Only	\$25.00		
- Raiser refinalience Deductible Flair	Employee & Spouse/Domestic Partner	\$56.92		
Waive Medical Coverage	Yes	Not Applicable		
Dental (Please select <u>one</u> dental plan below)	Dependent Options (with or without spouse/DP/children)	Employee Premium Share		
Delta Dental of Washington	Yes	\$0.00		
Dental Health Services+	Yes	\$0.00		
Vision (Please select <u>one</u> Vision Plan below)	Dependent Options (with or without spouse/DP/children)	Employee Premium Share		
VSP – Basic	Yes	\$0.00		
VSP – Buy Up**	Yes	\$10.38		

^{**}Temporary Benefits Eligible (TBE) employees are not eligible for the Vision Buy Up plan

Add Dependent Coverage Information:

List all eligible dependents to be included. Attach another page 2 for additional dependents. If you enroll a dependent, the City's business partner, Alight Solutions, will send a letter to your home requesting documents that confirm the eligibility of your dependent. For more information visit https://bit.ly/Citydev

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⁺Dental Health Services is a Limited Health Care Service Contractor (100 West Harrison Street, Suite S-440, South Tower, Seattle, WA 98119

Spouse / Domestic Partner											
Spouse Domestic Partner (Yes-IRS Tax Dependent) Domestic Partner (No-Not IRS Tax Dependent									Tax Dependent)		
		First Name		MI	SSN	SSN		Birth Date (mm/dd/yyyy)		Gender	
										Male Female X***	
Enroll In (check boxes as applicable)											
Dependent Child #1											
				ghter						egal Guardian on Daughter	
Relationship Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits Rep to begin verification process)											
	Fi	irst Name		MI	SSN					Gender	
						-	-			Male Female X***	
ooxes as applicable)		Medical	☐ Dei	ntal	□ v	ision					
		·									
hild #2											
Employee's Child		Stepchild r Son Daughter			Domestic Partner's Child Son Daughter			Legal Guardian Son Daughter			
Relationship Son Daughter Son											
				_	epto b	egin verif	fication pro	cess)			
	child is a			_	pto b		fication pro	cess) Birth Dat (mm/dd/y			
	child is a	ge 26 or older, co		enefits Re			fication pro	Birth Dat		Gender Male Female X***	
	child is a	ge 26 or older, co	ntact B	enefits Re	SSN	-	fication pro	Birth Dat		Male Female	
(If yes and your o	child is a	ge 26 or older, co First Name	ntact B	MI	SSN	-	-	Birth Dat		Male Female	
(If yes and your of open as applicable) hild #3 Employee	e's Child	ge 26 or older, co First Name Medical Stepch	ntact B	MI Mental	SSN	- Vision Domest	- ic Partner's	Birth Dat (mm/dd/y	Le	Male Female X***	
(If yes and your of open and you of open	e's Child Daugh	ge 26 or older, co First Name Medical Stepch ter Son ed or Disabled?	ntact B	enefits Re MI Dental	SSN	Vision Domest Son	- ic Partner's Daughte	Birth Dat (mm/dd/yn	yyy)	Male Female X***	
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	boxes as applicable) hild #1 Employee': Son Da Is the child inca (If yes and your boxes as applicable) hild #2 Employee'	boxes as applicable) hild #1 Employee's Child Son Daughter Is the child incapacitate (If yes and your child is poxes as applicable) hild #2 Employee's Child	First Name First Name First Name First Name	First Name Doxes as applicable	First Name MI Dooxes as applicable) Medical Dental Mid #1 Employee's Child Son Daughter Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits R First Name MI Dental Dental Dental Dental Dental Dental Dental Dental	First Name MI	First Name MI SSN coxes as applicable) Medical Dental Vision hild #1 Employee's Child Stepchild Domestic Son Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits Repto begin ver First Name MI SSN	First Name MI SSN Doxes as applicable) Medical Dental Vision Mid#1 Employee's Child Son Daughter Son Daughter Son Daughter Son Daughter Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits Rep to begin verification profits and your child is age 26 or older, contact Benefits Rep to begin verification profits Name MI SSN First Name MI SSN Doxes as applicable) Medical Dental Vision Mid#2 Employee's Child Son Daughter Son Daughter	First Name MI SSN Birth Date (mm/dd/yy) Doxes as applicable) Medical Dental Domestic Partner's Child Son Daughter Son Daughter Son Daughter Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits Rep to begin verification process) First Name MI SSN Birth Date (mm/dd/s) We son Daughter Domestic Partner's Child (mm/dd/s) First Name MI SSN Dowes as applicable) Medical Dental Domestic Partner's Child (mm/dd/s) Domestic Partner's Child Son Daughter Domestic Partner's Child Son Daughter	First Name MI SSN Birth Date (mm/dd/yyyy) Dowes as applicable)	

 $\ensuremath{^{***}}\xspace$ X means a gender that is not exclusively male or female

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Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

Coverage Acknowledgement:

I Accept Coverage

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize the City to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understood the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete or misleading information, or fail to update this information in accordance with eligibility guidelines.

Employee's Signature:

Date (mm/dd/yyyy):

I Waive Medical Coverage Only

I understand that by waiving City of Seattle medical insurance, my dependents and I will not have medical coverage through the City. I understand I must enroll in a vision and dental plan. I waive medical coverage for myself and my dependents.

Other opportunities to enroll in medical benefits in the future:

- If you have medical coverage elsewhere and lose your other coverage, you may enroll within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage. If you have a qualifying change in family status, you may enroll within 30 days (or 60 days for a new child/adoption) of that change. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law through the City; however, if you retire you will be eligible to enroll in a City retiree medical plan.
- If you decline coverage and have no medical insurance elsewhere, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law; however, if you retire you will be eligible to enroll in a City retiree medical plan.

Employee's Signature:

Date (mm/dd/yyyy):

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