

2024 SPOG

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	Birth/Adoption				
New Hire (Temporary Benefits Eligible - TBE)	Change Coverage	Loss of other coverage			
New Marriage/Domestic Partnership (Attach marriage/domestic partner affidavit form)	Name Change Only	(attach proof of other coverage)			
(Attachmannage/domestic partner amdavictorm)					

^{*}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			
Aetna Preventive Plan	Employee & Spouse/Domestic Partner	\$121.78			
Aetna Traditional Plan (LEOFF II)	Employee & Spouse/Domestic Partner	\$108.58			
Kaiser Permanente Standard Plan	Employee & Spouse/Domestic Partner	\$86.18			
Kaiser Permanente Deductible Plan	Employee & Spouse/Domestic Partner	\$63.88			
Waive Medical Coverage	Yes	Not Applicable			
Do Not Use	Do Not Use	Do Not Use			
Do Not Use Dental (Please select one dental plan below)	Do Not Use Dependent Options (with or without spouse/DP/children)	Do Not Use Employee Premium Share			
Dental	Dependent Options				
Dental (Please select <u>one</u> dental plan below)	Dependent Options (with or without spouse/DP/children)	Employee Premium Share			
Dental (Please select one dental plan below) Delta Dental of Washington	Dependent Options (with or without spouse/DP/children) Yes	Employee Premium Share \$0.00			

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

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

Revised 03/2024 Page **1** of **3**

Relationship Spouse First Name Mi SSN Birth Date (mm/dd/yyyy) Gender (Mryos and your child special on Daughter Son Daughter	Spouse/Don	nestic Partner												
Enroll In (theck books as applicable) Medical Dental Vision Male Female X**** Part Medical Dental Vision Male Female X**** Part Medical Dental Vision Male Female X**** Part Medical Dental Vision Medical Dental Medical Dental Medical Dental Medical Dental Medical Dental Medical Dental Dent	Relationship	Spouse	Do	Domestic Partner (Yes - IRS Tax Dependent) Domestic Partner (No - Not IRS Tax Dependent						S Tax Dependent)				
EnrollIn (check boxes as applicable) Medical Dental Vision	Last Name			First Name			М	I	SSN					Gender
Employee's Child Son Daughter Stepchild Son Daughter Son D			- This strains											Female
Employee's Child Son Daughter Son S	Enroll In (check b	poxes as applicable)		□ Ме	dical	l 🗆 ı	Den ⁻	ental Usion						
Relationship Relationship Is the child incapacitated or Disabled? Last Name First Name MI SSN Birth Date (mm/dd/ywy) Female X**** Enroll In (check boxes as applicable) Is the child incapacitated or Disabled? First Name MI SSN Birth Date (mm/dd/ywy) Female X**** Male Female X**** Enroll In (check boxes as applicable) First Name MI SSN Birth Date (mm/dd/ywy) Step Child Son Daughter Son	Dependent C	hild #1												
Is the child incapacitated or Disabled? Yes No (lif yes and your child/is age 26 or older, contact Benefits Repto begin verification process) Last Name	Relationship												_	
Employee's Child Son Daughter S	Kelationship		•						epto	begin ve	rification pr			_
Pependent Child #2 Relationship Employee's Child Son Daughter Dau	Last Name		F	irst Nar	me		М	ıı	SSN					Gender
Dependent Child #2 Employee's Child Son Daughter														Female
Relationship Relat	Enroll In (check boxes as applicable)			☐ Medical ☐ De		☐ De	nta	ı	☐ Vision					
Relationship Relat						•								
Son Daughter Son	Dependent C	hild #2												
Relationship Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits Repto begin verification process) Last Name First Name MI SSN Birth Date (mm/dd/yyyy) Gender Male Female X*** Enroll In (check boxes as applicable) Dependent Child #3 Employee's Child Son Daughter 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 Repto begin verification process) Last Name MI SSN Birth Date (mm/dd/yyyy) Gender Male Female X*** MI SSN Birth Date (mm/dd/yyyy) Gender Male Female X***			-	•										
Last Name First Name MI SSN Birth Date (mm/dd/yyyy) Gender Male Female X*** Enroll In (check boxes as applicable) Dependent Child #3 Employee's Child Son Daughter Son Daughte	Relationship			Son	Daughte		Si	on Daughter						
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Enroll In (check boxes as applicable) Medical Dental Vision	Last Name			First Na	ame			MI	SSN	I				Gender
Relationship Employee's Child Stepchild Son Daughter Son Daughter Son Daughter Son Daughter										-	-			Female
Relationship Employee's Child Stepchild Son Daughter Dau	Enroll In (check boxes as applicable)			☐ Medical ☐ De			Den [.]	tal		☐ Vision				
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Is the child incapacitated or Disabled? Yes No (If yes and your child is age 26 or older, contact Benefits Repto begin verification process) Last Name First Name MI SSN Birth Date (mm/dd/yyyy) Gender Male Female X***														•
(If yes and your child is age 26 or older, contact Benefits Rep to begin verification process) Last Name First Name MI SSN Birth Date (mm/dd/yyyy) Gender Male Female X***	Relationship								Son Daughter			Son Daughter		
Last Name First Name MI SSN (mm/dd/yyyy) Gender Male Female X***							t Beı		Repto	begin ve	erification pr	ocess)		
Female X***	Last Name			First Na	ame			MI	SS					
Enroll In (check boxes as applicable) Medical Dental Vision										-	-			Female
	Enroll In (check I	poxes as applicable)		☐ Me	dical		Den ⁻	tal		Vision				

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

Revised 03/2024 Page **2** of **3**

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):
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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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Revised 03/2024 Page **3** of **3**