**HEALTH CARE BENEFITS ELECTION FORM – MOST**

**NEW EMPLOYEE ENROLLMENT or**

**RE-ENROLLING AFTER WAIVING/DECLINING COVERAGE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | | |  |  | | | |  |  |
| Last Name (Please Print) | | | First Name | | |  | Employee Number | | | |  | Department |
|  | | | |  |  | | |  | | |  |  |
| Home Address - Street | | | |  | City | | | State | | |  | Zip |
|  |  |  | |  |  | | | |  | -- | | |
| Hire Date |  | Work Phone | |  | Birth Date (M/D/Y) | | | |  | Social Security Number | | |

New Hire  Re-Enrolling  Decline coverage (*skip to Page 2*) Effective Date of Coverage

**Reason for re-enrolling:**  Loss of other coverage (Attach proof of other coverage)  Birth/adoption of child

Marriage/new domestic partnership (Attach affidavit of marriage/domestic partnership)

Other

**Medical Plan Selection** **Employee Premium Share**

*(Please choose ONE Medical Plan below)*

**City of Seattle Preventive Plan**

Employee Only (with or without Children) $48.12

Employee & Spouse/Domestic Partner (with or without Children) $98.50

**City of Seattle Traditional Plan**

Employee Only (with or without Children) $ 0.00

Employee & Spouse/Domestic Partner (with or without Children) $32.34

**Kaiser Permanente Standard Plan**

Employee Only (with or without Children) $48.40

Employee & Spouse/Domestic Partner (with or without Children) $99.90

**Kaiser Permanente Deductible Plan**

Employee Only (with or without Children) $25.00

Employee & Spouse/Domestic Partner (with or without Children) $56.92

**Vision Plan**

Basic Vision Service Plan $ 0.00

Buy-Up Vision Service Plan $10.38

**Dental Plan Selection** *(Please choose ONE Dental Plan)*

Dental Health Services\* **OR**  Delta Dental of Washington $ 0.00

**Add Dependent Coverage Information:** List all eligible dependents to be included. Attach list for any additional dependents. If you enroll a dependent, Aon Hewitt, the City’s business partner, will send a letter to your home requesting documents that confirm the eligibility of your dependent.  Information at [www.seattle.gov/personnel/benefits/life/dependenteligibility.asp](http://www.seattle.gov/personnel/benefits/life/dependenteligibility.asp).

**Spouse/Domestic Partner** **Birth Date Enroll In**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | **Yes  No** | **Yes  No** |
| Last Name | First Name | MI |  | Social Security Number |  | (M/D/Y) | Medical | Dental/Vision |

*Relationship*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Spouse**  Male  Female | **OR** | **Domestic Partner**  Male  Female |  | Partner claimed as IRS tax dependent Yes  No |

**1. Dependent Child** **Birth Date Enroll In**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | **Yes  No** | **Yes  No** |
| Last Name | First Name | MI |  | Social Security Number |  | (M/D/Y) | Medical | Dental/Vision |

*Relationship*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employee’s Dependent** | **OR** | **Partner’s Dependent** | **OR** | **Other** (Step-child or Legal Guardian) |
| Son  Daughter |  | Son  Daughter |  | Male  Female |

**THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED ON THE REVERSE SIDE**

**2. Dependent Child** **Birth Date Enroll In**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | **Yes  No** | **Yes  No** |
| Last Name | First Name | MI |  | Social Security Number |  | (M/D/Y) | Medical | Dental/Vision |

*Relationship*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employee’s Dependent** | **OR** | **Partner’s Dependent** | **OR** | **Other** (Step-child or Legal Guardian) |
| Son  Daughter |  | Son  Daughter |  | Male  Female |

**3. Dependent Child** **Birth Date Enroll In**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | **Yes  No** | **Yes  No** |
| Last Name | First Name | MI |  | Social Security Number |  | (M/D/Y) | Medical | Dental/Vision |

*Relationship*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employee’s Dependent** | **OR** | **Partner’s Dependent** | **OR** | **Other** (Step-child or Legal Guardian) |
| Son  Daughter |  | Son  Daughter |  | Male  Female |

**Dependent Eligibility Information:** If you have listed a dependent child over the age of 18 years, please answer the questions below about your dependent:

1. Incapacitated or Disabled?  Yes  No 2. Working full time and have access to health insurance? Yes  No

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 include imprisonment, fines and denial of insurance benefits.

\* **Dental Health Services is a Limited Health Care Service Contractor**

100 West Harrison Street, Suite S-440, South Tower, Seattle, WA 98119

**Coverage Options**

**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 understand 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.

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Employee’s signature Date

**I DECLINE COVERAGE**

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 31 days (or 60 days for a new child) 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 or enroll in a City retiree medical plan.

I understand that by declining City of Seattle medical insurance, my medical coverage through the City will end, but my vision and dental insurance will continue.  ***I decline medical coverage for myself and family members.***

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Employee’s signature Date

|  |
| --- |
| Department Representative’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Entered into HRIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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