



# Employee Data Maintenance Form

Human Resources Office • City Hall - Room 313  
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**2012 OPEN ENROLLMENT  
 ACTIVE EMPLOYEE**

Benefits Effective Date: 01/01/2012  
 First Payroll Deduction: 01/06/2012

All Open Enrollment forms must be returned to Human Resources (City Hall - Room 313) by 4:30 p.m. on Monday, December 5, 2011.

## SECTION A: EMPLOYEE INFORMATION

Full Name			Social Security Number		
Mailing Address					Date of Birth
City	State	Zip	Home Phone		
Email Address			Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Cell Phone
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Bargaining Unit	<input type="checkbox"/> Basic <input type="checkbox"/> Police	<input type="checkbox"/> Confidential <input type="checkbox"/> Supervisory <input type="checkbox"/> Fire <input type="checkbox"/> LELS
Department		Division		Work Phone	
					Date of Hire

## SECTION B: HEALTH PLAN ELECTION – Comprehensive Hospital / Medical Benefit Plan 3A

Health Election:  Single  Family

## SECTION C: DENTAL PLAN ELECTION

NOTE: Employees electing Employee + Spouse / Child or Family coverage shall maintain such coverage for not less than two (2) consecutive years.

Dental Election:  Employee  Employee + Spouse  Employee + Child  Family  Waive Dental (Part-Time Employees Only)

Coverage Election:  Low Option - \$1,000 Annual Benefit (\$1,500 for Confidential)  High Option - \$2,000 Annual Benefit

## SECTION D: DEPENDENT INFORMATION

If you wish to add or cancel coverage for dependents, you must complete this section. Enter dependent information, then in the appropriate benefits column indicate "A" to add dependent coverage or "C" to cancel existing dependent coverage.

Full Name of Dependent	Social Security Number	Date of Birth	Gender	Relationship to Employee	(A)dd or (C)ancel	
					Health	Dental

## SECTION E: ADDITIONAL INSURANCE INFORMATION - MEDICARE, MEDICAID OR OTHER COVERAGE

If you or any dependents listed above are eligible for Medicare, Medicaid, and/or other insurance, fill out Section E and attach a copy of the insurance card(s).

Full Name of Insured	Coverage Type (Medicare, Medicaid, or other insurance)	Policy Number	Medicare Part A Effective Date	Medicare Part B Effective Date

## SECTION F: AUTHORIZATION AND SIGNATURE

I hereby certify by my signature on the enrollment form that the foregoing information provided by me is true and correct, and that I have read and accept the conditions described in the enrollment material. I acknowledge having read the information provided to me and agree to all of the terms as defined by the plans I have selected, and I authorize the required deduction (if any) from my wages. By signing this form, I attest that I have reviewed the "Dependent Eligibility Requirements" and that the information I am submitting is true and accurate. I understand that providing false information or omission of relevant information on this form may result in the denial of claims, cancellation or rescission of coverage, and the City of Duluth or Duluth Joint Powers Enterprise Trust may be required to take action to recover funds expended due to fraud or fiscal misconduct. I also understand that it is my duty to notify the City of Duluth Human Resources Office of any changes provided by me on this form, including changes to the eligibility status of my dependents.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FOR INTERNAL USE ONLY: Date: \_\_\_\_\_ Payroll: \_\_\_\_\_ Auditor: \_\_\_\_\_ Exit DB: \_\_\_\_\_ Payroll Start Date: 01/06/12  
 Health Group # 25077 HealthPartners: \_\_\_\_\_ RX # NPSCD P1 NPS: \_\_\_\_\_ Active DB: \_\_\_\_\_ New World: \_\_\_\_\_  
 Dental Group # 000405- Delta Dental: \_\_\_\_\_ Genesis QB: \_\_\_\_\_ Genesis SPM: \_\_\_\_\_ Retiree DB: \_\_\_\_\_ OPEN ENROLLMENT 2012

## DEPENDENT ELIGIBILITY REQUIREMENTS

Your family members may be covered under the Duluth Joint Powers Enterprise Trust sponsored health and welfare benefit plans as long as they meet the eligibility requirements:

1. Spouse - Legally married or legally separated opposite gender spouse;
2. Dependent Child - Birth through age 25 (up to the child's 26th birthday):
  - a.) An eligible child can include your unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild or any other child who state or federal law requires be treated as a dependent. *In order to qualify as an eligible dependent under the health plan, working adult children (ages 19 and older) must not be eligible for group health coverage through their employer.*
  - b.) A grandchild you claim as an exemption on your Federal income tax return and who is financially dependent upon you.
  - c.) A child of the employee who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO).