



Employee Data Maintenance Form

City of Duluth - Human Resources
 411 W. 1st Street • Room 313 • Duluth, Minnesota • 55802
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For HR Use Only	
Benefits Effective Date:	_____
Payroll Start Date:	_____
First Payroll Deduction:	_____

Deadline and Defaults: *You have 31 days from your date of hire or from the "Date of Event", listed under Section B: Reason for Enrollment or Change, to complete and file this form with the City of Duluth's Human Resources Office. If you are making a change, please refer to your Benefits Handbook and/or the flyer regarding "Family Status Changes" for additional information.*

Be sure to fully complete your choices for each benefit and record your selections carefully. Failure to make a specific benefit election on this form will be considered your decision to keep your current benefit election or accept the default enrollment outlined in your current collective bargaining agreement. Once you complete and submit this form, it will be recorded as your election until the next Open Enrollment. You will not be able to make changes to your enrollment elections unless you have a qualified status change.

SECTION A: EMPLOYEE INFORMATION

Full Name (Last, First, Middle)			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"/> Confidential <input type="checkbox"/> Supervisory <input type="checkbox"/> Legislative & Executive	<input type="checkbox"/> Fire <input type="checkbox"/> LELS <input type="checkbox"/> Police	Work Phone
Department		Date of Hire	
Division			

SECTION B: REASON FOR ENROLLMENT OR CHANGE (check all that apply)

Documentation is required for all qualifying status-change events & adding/canceling dependents

DATE OF EVENT: _____	
<input type="checkbox"/> New Employee	<input type="checkbox"/> Change in employment status (e.g., a change affecting eligibility for health and/or dental benefits)
<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Spouse and/or child loses other coverage
<input type="checkbox"/> Marriage	<input type="checkbox"/> Child is ineligible (refer to "Dependent Eligibility Requirements")
<input type="checkbox"/> Divorce/Annulment	<input type="checkbox"/> Judgment or decree (i.e., Qualified Medical Child Support Order or Legal Guardianship)
<input type="checkbox"/> Death	<input type="checkbox"/> Other: _____

SECTION C: HEALTH PLAN ELECTION — Comprehensive Hospital-Medical Benefit Plan 3A

<input type="checkbox"/> Single	Employees electing <u>single health coverage</u> must complete a Deferred Compensation Plan and/or a Flexible Spending Account enrollment form. Refer to your collective bargaining agreement and your Benefits Handbook for further information.
<input type="checkbox"/> Family	Employees electing <u>family health coverage</u> must elect to apply the Deferred Compensation employer contribution to either the Family Health Premium or to a Deferred Compensation Plan.
Elect One: <input type="checkbox"/> Family Health Premiums <input type="checkbox"/> Deferred Compensation Plan	
If electing to apply the employer contribution to the Deferred Compensation Plan, you must complete a Deferred Compensation Plan enrollment form. Refer to your collective bargaining agreement and your Benefits Handbook for further information.	

SECTION D: DENTAL PLAN ELECTION

<input type="checkbox"/> Employee Only	Employees electing Employee + Spouse, Employee + Child, or Family dental coverage shall maintain such coverage for not less than two (2) consecutive years.	Elect One:	
<input type="checkbox"/> Employee + Spouse		<input type="checkbox"/> Low Option - \$1,000 Annual Benefit (\$1,500 for Confidential)	
<input type="checkbox"/> Employee + Child		<input type="checkbox"/> High Option - \$2,000 Annual Benefit	
<input type="checkbox"/> Family		<input type="checkbox"/> Waive Dental Plan (Part-Time Employees Only)	

SECTION E: DEPENDENT INFORMATION (to add or cancel coverage for dependents, you must complete Section E)

Enter dependent information, then in the appropriate benefits column indicate "A" to add dependent coverage or "C" to cancel existing dependent coverage.

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

SECTION F: MEDICAID OR MEDICARE INFORMATION

If you or any of your dependents listed above are eligible for Medicaid or Medicare, provide the following information and attach a copy of the Medicaid or Medicare card.

Full Name (Last, First, MI)	Medicaid or Medicare Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date

SECTION G: EMERGENCY CONTACT INFORMATION

Name	Home Phone	Other Phone <input type="checkbox"/> Cell <input type="checkbox"/> Work	Relationship to Employee

SECTION H: 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 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: _____

Employee Responsibility for Completing Forms	Dependent Eligibility Requirements
<p><u>When a qualifying family status change event occurs, you are responsible for completing the benefit enrollment form(s) to:</u></p> <ol style="list-style-type: none"> Add or cancel dependent medical and/or dental coverage; Make changes to your Flexible Spending Account (medical and dependent daycare); Make changes to your life insurance coverage, beneficiary election, PERA Pension Benefit, and/or Deferred Compensation Plan(s). 	<p><u>Your family members may be covered under your City of Duluth sponsored health and welfare benefit plans as long as they meet the eligibility requirements:</u></p> <ol style="list-style-type: none"> Spouse - Legally married or legally separated opposite gender spouse; Dependent Child - Birth through age 25 (up to the child's 26th birthday): <ol style="list-style-type: none"> 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. <i>In order to qualify as an eligible dependent under the City of Duluth's health plan, working adult children (ages 19 and older) must not be eligible for group health coverage through their employer.</i> A grandchild you claim as an exemption on your Federal income tax return and who is financially dependent upon you. A child of the employee who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO).

FOR INTERNAL USE ONLY: Health Group # _____ RX # NPSCD P1 _____ Dental Group # 000405- _____ Active Database: _____

Date: _____ HealthPartners: _____ NPS: _____ Delta Dental: _____ Retiree Database: _____

Payroll: _____ New World: _____ Genesis QB: _____ Deferred Comp: _____ Exit Database: _____

Auditor: _____ Minnesota Life: _____ Genesis SPM: _____ Fund: _____ Dept: _____ Div: _____ Cost Center: _____