



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: _____

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 submit this form to the City of Duluth's Human Resources Office. 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			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		Bargaining Unit		Work Phone	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		<input type="checkbox"/> Non-Union <input type="checkbox"/> Basic <input type="checkbox"/> Fire <input type="checkbox"/> Confidential <input type="checkbox"/> Police <input type="checkbox"/> LELS <input type="checkbox"/> Supervisory		Date of Hire	
Department			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: _____

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

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

Health Election: Single Family

SECTION D: DENTAL PLAN ELECTION

Individuals 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 E: 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 F: 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 F 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 G: EMERGENCY CONTACT INFORMATION

Full 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 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: _____

A family status change is a personal event that warrants a review of employee benefits. The checklist below explains how your benefits may be affected, and the actions you should take, for the following family status change events:

- Marriage, Divorce, Annulment
- Child's loss of eligibility for coverage
- Death of an eligible family member
- Entitlement to Medicare or Medicaid
- Change in employment status (gain or loss of employment, layoff, or a change that affects health and dental benefit plan eligibility)
- Judgment or decree (i.e., Qualified Medical Child Support Order)
- Birth, Adoption or placement for adoption, Gain or Loss of a stepchild or legal ward to your family

FAMILY STATUS CHANGES BENEFIT CHECKLIST

Plan Requirements for Submitting Your Enrollment Change Request

If you experience a qualifying family status change event, you can enroll or remove family members from your health and/or dental coverage or make a change to your current Flexible Spending Account election within 31 days from the date of the event. For example, the day you marry, the birth date of your newborn child, etc. Human Resources must receive your benefit election change request within 31 days from the date of the qualifying family status change. If you miss the 31-day window for submitting your enrollment forms, you must wait until the following Open Enrollment period to make a change to your benefit elections.

"Consistency Rule"

For an election change to be permitted, a qualifying event must have occurred and the election change request must be consistent with the event. For example, if you have single health and dental coverage and you subsequently get married you may add your spouse to your health and/or dental coverage within 31 days from the date you marry.

Dependent Eligibility Requirements

Your family members may be covered under the Duluth JPE 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).

Employee Responsibility for Completing Forms

When a qualifying family status change event occurs, you are responsible for completing the benefit enrollment form(s) to:

1. Add or cancel dependent medical and/or dental coverage;
2. Make changes to your Flexible Spending Account (medical and/or dependent daycare);
3. Make changes to your life insurance coverage, beneficiary election, PERA Pension Benefit, and/or Deferred Compensation Plan(s).

FOR INTERNAL USE ONLY: Health Group # 25077 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: _____