



Benefits Enrollment Form

City of Duluth - Human Resources
 411 W. 1st Street • Room 313 • Duluth, Minnesota • 55802
 218-730-5210 • Fax: 218-730-5906 • hrintformation@duluthmn.gov

2015 OPEN ENROLLMENT ACTIVE EMPLOYEE

Benefits Effective Date: 01/01/2015
 First Payroll Deduction: 01/02/2015

All Open Enrollment forms must be returned to Human Resources (City Hall - Room 313) by 4:30 p.m. on Monday, November 17, 2014. Forms only need to be completed/returned if you are making any changes or additions to your elections.

SECTION A: EMPLOYEE INFORMATION

Full Name: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of Birth: _____

Department: _____ Date of Hire: _____

Division: _____ Bargaining Unit: Non-Union
 Basic LELS
 Confidential Police
 Supervisory Fire

Gender: Female Male
 Marital Status: Single Married Widowed Legally Separated
 Status: Full-Time Part-Time

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

Coverage Election: Single Family

I decline health care coverage and have enclosed proof of other health care coverage

SECTION C: DENTAL PLAN ELECTION

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

2. Coverage Election: Low Option - \$1,000 Annual Benefit High Option - \$2,000 Annual Benefit

SECTION D: DEPENDENT INFORMATION

If you wish to add or cancel dependent coverage, you must complete this section.

Full Name of Dependent	Social Security Number	Date of Birth	Gender	Relationship to Employee	Health	Dental
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel

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

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 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.
 - 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).