City of Lowell

2023-24 Group Benefits Enrollment/Change Form

Please return completed form to Human Resources.

Date of Hire:

A. EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Birthdate	Gender

Street Address	Apt. No.	City	State	Zip Code

Phone	Social Security Number	Marital Status
		❑ Single ❑ Legally Married ❑ Widowed ❑ Divorced ❑ Legally Separated

B. FAMILY INFORMATION (list all family members to be covered)

Dependents Name (First, Middle Initial, Last)	**Gender** M or F	**Birthdate** Mo./Day/Year	**Relationship to Applicant**	**Social Security Number**

C. MEDICAL, DENTAL, AND VISION INSURANCE

MEDICAL: UnitedHealthcare

- ❑ Employee Only – $25/month
- ❑ Employee + Family – $212/month
- ❑ DECLINE

DENTAL: Delta Dental

- ❑ Employee Only – $5/month
- ❑ Employee + Family – $30/month
- ❑ DECLINE

VISION: Superior Vision

- ❑ Employee Only – $2/month
- ❑ Employee + Family – $4/month
- ❑ DECLINE

D. GROUP LIFE/AD&D PLAN

Standard	**Amount of Coverage**	**Policy #171358**
Group Life and Accidental Death & Dismemberment Policy	Enrolled: **$50,000**; Doubles for Accidental Death	Provided at no cost – 100% paid by The City of Lowell

Employee Name: _____

E. VOLUNTARY LIFE & ACCIDENTAL DEATH & DISMEMBERMENT		
Standard	**Amount of Coverage**	**Policy #171358**
EMPLOYEE ($150,000 Guarantee Issue) SPOUSE ($15,000 Guarantee Issue) CHILD(REN) ($10,000 Guarantee Issue)	☐_____ ☐ _____ ☐ _____	☐ **DECLINE Voluntary Life/AD&D** *See page 4 for benefit amount options. $_____ total monthly rate
F. SHORT-TERM DISABILITY		
Standard		**Policy #171358**
STD benefit pays up to 60% of your weekly earnings. See Benefits at a Glance for more detail.	Enrolled	Provided at no cost – 100% paid by The City of Lowell
G. LONG-TERM DISABILITY		
Standard		**Policy #171358**
LTD benefit pays up to 60% of your monthly earnings. See Benefits at A Glance for more detail.	Enrolled	Provided at no cost – 100% paid by The City of Lowell
H. ACCIDENT COVERAGE		
Standard	**Monthly Rate**	**Policy #171358**
The Accident Plan pays a lump-sum benefit if you experience a covered accident or injury. See Benefits at a Glance for more details.	❑ Employee Only - $12.09/month ❑ Employee + Spouse - $18.95/month ❑ Employee + Child(ren) -$22.88/month ❑ Employee + Family $35.89/month	❑ DECLINE
I. CRITICAL ILLNESS COVERAGE		
Standard	**Monthly Rate**	**Policy #171358**
The Critical Illness Plan helps supplement your major medical coverage by providing a lump-sum benefit if you experience a covered illness. See Benefits-at-a-glance for more details.	☐ **ACCEPT** **$_____ monthly rate** *Rates located on page 4.*	☐ DECLINE
J. HOSPITAL INDEMNITY COVERAGE		
Standard	**Monthly Rate**	**Policy #171358**
Hospital Indemnity insurance pays cash benefits to employees in the event of a hospitalization regardless of treatment costs or other insurance coverage. It's an affordable way for employees to keep their finances on track.	❑ Employee Only - $18.10/month ❑ Employee + Spouse - $30.82/month ❑ Employee + Child(ren) -$26.03/month ❑ Employee + Family $46.03/month	❑ DECLINE

Employee Name: _____

K. BENEFICIARY DESIGNATION

Please indicate who you would like to receive your life insurance benefit in the event of your death below and indicate whether they are Primary or Contingent. Benefits are paid to contingent beneficiaries only if there is no surviving Primary Beneficiary(ies). If multiple Primary or Contingent beneficiaries are selected and no percentage distribution is noted, then any benefits payable will be split equally.

Full Name	Relationship	Primary/Contingent (circle one)	Benefit Percentage
		Primary Contingent	
		Primary Contingent	
		Primary Contingent	

L. PRE-TAX AND POST-TAX BENEFIT ELECTIONS

Effective Date	Coverage	Pre-Tax Election (EE ES EC F)	Per Month
	Medical		
	Dental		
	Vision		
		Pre-Tax Election Total	

Effective Date	Coverage	Post-Tax Election	Per Month
	Voluntary Life/AD&D		
	Accident		
	Critical Illness		
	Hospital Indemnity		
		Post-Tax Election Total	
		Pre + Post Tax Election Total	

M. AUTHORIZATION OF DEDUCTIONS UNDER "SECTION 125"

Section 125 of the Internal Revenue Code allows participants to save taxes by electing to pay their share of premiums for medical, dental, and vision coverages on a pre-tax basis. By signing below you are authorizing City of Lowell to deduct these premiums from your pay check on a pre-tax basis. In order to capture the tax savings, certain restrictions have been placed on the plan such as you will not be able to make a plan change until the end of the plan year or a qualifying event occurs. This means that you are committed to paying the premium you select every pay period for the plan year. Should you desire to deduct your costs on an "after tax" basis, please contact Human Resources for a Section 125 waiver form.

Employee Name: _____

N. CONDITIONS OF COVERAGE

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby declare all answers to be true and comply with the best of my knowledge. I have read and agreed with the terms as stated on this application. By acceptance of coverage and upon signing this enrollment form, I authorize each benefit provider, and others it designates, to share information about me with any medical provider, or other entity, where such information is reasonable necessary for treatment, payment or health care operations. I understand that the benefit providers may release information regarding services provided under my health benefits contract when requested by the organization sponsoring my benefits plan

This Enrollment/Change Form is provided to you as a convenience to eliminate paperwork from each benefit provider. However, this form will not cover every conceivable benefit election situation. Please contact human resources for benefit election forms for late enrollment or other situations not addressed in this form. In addition, please refer to human resources and information provided to you about specific questions you may have about your eligibility and benefit coverage. I understand that providing false information or omission of relevant information in this application may result in the denial of claims, cancellation or rescission of coverage.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature _____ Date _____ Plan Administrator Signature _____ Date _____

Attachments to enrollment form include: Summary of Benefits and Coverage (SBC), Glossary of Health Coverage and Medical Terms and Health & Welfare ERISA notices

VOLUNTARY LIFE/AD&D – EMPLOYEE, SPOUSE, & CHILD PREMIUMS			
	MONTHLY RATE PER $1000	SPOUSE	CHILD
AGE <25	$0.115	$0.115	$0.23
25-29	$0.155	$0.155	
30-34	$0.195	$0.195	
35-39	$0.235	$0.235	
40-44	$0.345	$0.345	
45-49	$0.425	$0.425	
50-54	$0.645	$0.645	
55-59	$0.995	$0.995	
60-64	$1.235	$1.235	
65-69	$1.735	$1.735	
70+	$4.395	$4.395	
*RATES INCLUDE AD&D			

HOW TO CALCULATE VOLUNTARY LIFE COSTS BASED ON AMOUNT ELECTED	
1. Enter the rate per $1,000 based on employee's age	$
2. Add employee & spouse amounts together. Take the amount of insurance and divide by $1,000	
3. Multiply lines 1 and 2 **(this is your monthly cost)**	$
Monthly cost for your child(ren) - $0.23 Covers all eligible	$
Total Life and AD&D Insurance	$

CRITICAL ILLNESS - ATTAINED AGE MONTHLY PREMIUMS						
EMPLOYEE RATES						
AMOUNT	18-29	30-39	40-49	50-59	60-69	70+
$10,000	$3.90	$5.90	$12.20	$25.20	$46.80	$119.00
$20,000	$7.80	$11.80	$24.20	$50.40	$93.60	$238.00

CRITICAL ILLNESS - ATTAINED AGE MONTHLY PREMIUMS						
SPOUSE RATES						
AMOUNT	18-29	30-39	40-49	50-59	60-69	70+
$5,000	$1.95	$2.95	$6.10	$12.60	$23.40	$59.50
$10,000	$3.90	$5.90	$12.20	$25.20	$46.80	$119.00