Group Benefits Enrollment/Change Form

Please return completed form to Finance Department (Darcy Richard).

Date of Hire:

A. EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Date of Birth	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); Check Medical, Dental and Vision if to be covered under those plans.

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

C. MEDICAL, DENTAL AND VISION INSURANCE

MEDICAL: United Healthcare	**DENTAL: Arkansas Blue Cross**	**VISION: Superior Vision**
❑ Employee Only	❑ Employee Only	❑ Employee Only
❑ Employee + Family	❑ Employee + Family	❑ Employee + Family
❑ DECLINE	❑ DECLINE	❑ DECLINE

D. MEDICAL, DENTAL AND VISION MONTHLY PREMIUMS

COVERAGE TYPE	**COST PER PAYROLL PERIOD***	**TOTAL COST PER MONTH**
❑ Employee Only	$16.00 per payroll period	$32 per month
❑ Employee + Family	$123.00 per payroll period	$246 per month

*Payroll is on a bi-weekly schedule. Insurance premiums are deducted on the 1st and 2nd payrolls for each month. If a month has a 3rd payroll, no premiums will be deducted for that payroll period.

Employee Name: ___________________________________

E. GROUP LIFE/AD&D PLAN

United Healthcare	Amount of Coverage	Policy No. G/GA5U5868NM
Group Life and Accidental Death & Dismemberment policy	$15,000 benefit for Life; Doubles for Accidental Death	Only employees enrolled in the Medical Plan are eligible for this plan. City of Lowell pays 100% of this premium for eligible employees.

F. 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	

G. 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.

I elect the insurance coverage as marked on Page 1 of this enrollment form. I authorize the City of Lowell to deduct insurance premiums from my paycheck.

_______________________________________ _______________________________________

Employee Signature Date Plan Administrator Signature Date