City of Fort Oglethorpe
Insurance Enrollment / Cancellation Request

Refer to the Benefit Summary sheet for premium information
Refer to the Summary of Benefits for plan details

To be completed by Employer

New Enrollment/Additions: (Check one)
Date of Hire _____ /____ /_____
Effective Date of Enrollment _____ /____ /_____
☐ New Hire ☐ Status Change (PT to FT)
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ **Annual Open Enrollment**

☐ **Cancellations:**
Last Date of Employment _____ /____ /_____
Effective Date of Cancellation _____ /____ /_____
☐ Cancel all coverage
☐ Cancel as listed below in Section 4
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Dependent reached max age
☐ Other (describe)_____

1. Employee General Information

Last Name	First Name	MI	Social Security #

Address	City	State	Zip

Birthdate	Phone #	Email Address

Gender
☐ Male ☐Female

Marital Status
☐ Single ☐Married: ____/____/____

Salary
_____

********* Per City Policy; as of January 1, 2018 if your Spouse is eligible for Medical Insurance through their employer they are <u>not</u> eligible to enroll for Medical Insurance in the City of Fort Oglethorpe's Medical Plan.**

If electing Medical coverage for your Spouse please provide the following information:
Is your Spouse employed ☐ YES ☐ NO If yes, Employer's name _____
Employer's phone # _____

Is your Spouse eligible for Medical Insurance through their employer ☐ YES ☐ NO If yes, complete the Waiver of Coverage in Section 2 and do **<u>not</u>** select Medical coverage for your spouse in Section 3

2. Waiver of Coverage

I decline coverage for:	Please mark reason for declining coverage	Insurance Carrier	Policy #
☐ Myself	☐ I am covered under another Plan		
☐ Dependents	☐ My dependents are covered under another Plan		
☐ Spouse	☐ My Spouse is covered under another Plan		
	☐ I (we) have no other coverage at this time		

"IMPORTANT INFORMATION"
I understand that if I decline coverage for myself or eligible dependents, I will not be allowed to change my election until the next Open Enrollment period or unless I experience a qualifying status change such as marriage, divorce, birth, change in employment, etc. I understand that it is my responsibility to inform my employer of any status change immediately and request enrollment changes related to status change within 30 days of such status change. I understand that if I cancel or decline coverage for myself or eligible dependents due to the existence of other coverage, I may be able to enroll myself and/or eligible dependents in this plan, provided that I request enrollment changes within 30 days after such loss of coverage

3. Select Plan Options

Please select coverage choices….
Employee must be enrolled to select dependent coverage

Select either Base or Buy Up

Covered Member	Medical		Covered Member	Vision		Covered Members	Dental Base ($1,000/yr benefit)	Dental - Buy Up ($1,500/yr benefit)
Employee	☐		Employee	☐		Employee	☐	☐
Emp. + 1	☐		Emp. + 1	☐		Emp. + Child(ren)	☐	☐
Family	☐		Family	☐		Emp. + Spouse	☐	☐
Waive	☐		Waive	☐		Family	☐	☐
						Waive	☐	☐

4. Dependent Information - List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box				Gender	Relationship	
Yes	No	Coverage		M		
☐	☐	Medical	First Name MI Last Name	F	Spouse	
☐	☐	Dental			Birthdate	
☐	☐	Vision	Social Security		/ /	

Check appropriate box				Gender	Relationship	Full Time Student
Yes	No	Coverage		M		☐ YES
☐	☐	Medical	First Name MI Last Name	F		☐ NO
☐	☐	Dental			Birthdate	
☐	☐	Vision	Social Security		/ /	

Check appropriate box				Gender	Relationship	Full Time Student
Yes	No	Coverage		M		☐ YES
☐	☐	Medical	First Name MI Last Name	F		☐ NO
☐	☐	Dental			Birthdate	
☐	☐	Vision	Social Security		/ /	

Check appropriate box				Gender	Relationship	Full Time Student
Yes	No	Coverage		M		☐ YES
☐	☐	Medical	First Name MI Last Name	F		☐ NO
☐	☐	Dental			Birthdate	
☐	☐	Vision	Social Security		/ /	

Check appropriate box				Gender	Relationship	Full Time Student
Yes	No	Coverage		M		☐ YES
☐	☐	Medical	First Name MI Last Name	F		☐ NO
☐	☐	Dental			Birthdate	
☐	☐	Vision	Social Security		/ /	

5. Life Insurance Options

Group Life (Employee only)	Optional Supplement Life (Employee only)
☑ $50,000 policy paid by City	**Select one…….**
	☐ 1 x Salary ☐ 2 x Salary ☐ I do not want this coverage
	*** Premiums rise as you enter the next five-year age bracket or with Salary Increases
	*** Evidence of Insurability required for policy amounts over $75,000

"IMPORTANT INFORMATION" ******** Policy amounts are subject to a 35% reduction at age 65 and 50% reduction at age 70**

Name your Beneficiaries (primary beneficiaries must total 100%)

Primary Beneficiary:

Name _____ **Relationship** _____ **%** _____

Name _____ **Relationship** _____ **%** _____

Contingent Beneficiary: (In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit)

Name _____ **Relationship** _____ **%** _____

6. Signature

I understand that under (COBRA), I can continue medical, dental and vision insurance benefits for myself and my covered eligible dependents upon termination of my employment.

By my signature below, I acknowledge that I have read and understand the "Important Information" disclosed in this Enrollment/Cancellation Form. I authorize the required payroll deductions for contributory benefits. I also represent that all information shown on this Enrollment/Cancellation Form is correct and true to the best of my knowledge. Should changes take place affecting these statements it is my responsibility to immediately inform my employer of the change.

Employee Signature _____ **Date signed** _____