CITY OF DE PERE
Employee Health/Dental/Vision
Enrollment, Cancellation, and Waiver Form

GENERAL INFORMATION

Benefit Effective Date*

___/___/___

Employee Name _____ Date of Birth ____/_____/_____

Social Security # _____ Male ☐ Female ☐

Home Address _____
Street Address

_____
City State Zip Code

Home Phone (_____)_____ Home E-mail _____

Department _____ Single ☐ Married ☐

Benefit effective date to enroll in coverage may be either the date of the qualifying event, or the first of the month following the qualifying event.* **Employees pay the full monthly premium regardless of the coverage effective date. *Insurance effective date to waive coverage is the last day of the month. Insurance coverage will continue through 11:59 p.m. on the last day of the month.*

PURPOSE OF COMPLETING FORM (Check one option below)

Date of Hire (only for new hires) ____/_____/_____

☐ New Hire
☐ Termination of **Dependent** Coverage Only
☐ Termination of **Employee & Dependent** Coverage
☐ Open Enrollment

Date of Qualifying Event^ ____/_____/_____

☐ Birth ☐ Marriage ☐ Adoption ☐ Divorce
☐ Court Ordered Dependent
☐ Other _____
☐ Notice of Waiving Coverage

^You must apply for coverage within 31-calendar days of a qualifying life event or 60 days for birth or adoption.

HEALTH INSURANCE

Check only one of the following boxes for health coverage. Check the waiver box if you are declining coverage.

Select coverage option or waiver of health insurance coverage	I elect the following **Health** insurance coverage: ☐ Single Coverage ☐ Employee +1 ☐ Family Coverage
	☐ I **Waive** health insurance coverage for myself and my dependent(s).
Termination Date: _____/____/_____	I would like to **Terminate** the following health insurance coverage: ☐ Single Coverage ☐ Employee +1 ☐ Family Coverage
Other Coverage	Do you have other health insurance coverage that you will be keeping? ☐ Yes ☐ No

SPOUSE AND/OR DEPENDENT INFORMATION:

If you are applying for coverage for your spouse and/or dependent(s) please provide the information requested below:

Put an X if Dep. is a new add to the plan.	Name (First, Middle initial, Last)	Relationship	Date of Birth	Female/ Male	Social Security Number

This Enrollment Form explains the general purpose of the insurance described, but in no way changes or affects the policy(s) actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. The benefit product contains limitations and exclusions, complete coverage information can be found in your Booklet-Certificate if you become insured. Please read it carefully and keep it in a safe place with your other important papers.

DENTAL INSURANCE

Check only one of the following boxes for dental coverage. Check the waiver box if you are declining coverage.

Select the dental insurance options or waiver of dental insurance coverage	I elect the following **Dental** insurance coverage: ☐ Delta Dental Single Coverage ☐ Dental Associates Single Coverage ☐ Delta Dental Family Coverage ☐ Dental Associates Family Coverage
	☐ I **Waive** dental insurance coverage for myself and my dependent(s).
Termination Date: _____/____/_____	I would like to **Terminate** the following dental insurance coverage: ☐ Delta Dental Single Coverage ☐ Dental Associates Single Coverage ☐ Delta Dental Family Coverage ☐ Dental Associates Family Coverage

SPOUSE AND/OR DEPENDENT INFORMATION:
If you are applying for coverage for your spouse and/or dependent(s) please provide the information requested below:

Put an X if Dep. is a new add to the plan.	Name (First, Middle initial, Last)	Relationship	Date of Birth	Female/ Male	Social Security Number

VOLUNTARY VISION INSURANCE

Check only one of the following boxes for voluntary vision coverage. Check the waiver box if you are declining coverage.

Select the voluntary vision insurance options or waiver of voluntary vision insurance coverage	I elect the following **Voluntary Vision** insurance coverage: ☐ Single Coverage ☐ Employee + Child(ren) Coverage ☐ Employee + Spouse Coverage ☐ Family Coverage
	☐ I **Waive** voluntary vision insurance coverage for myself and my dependent(s).
Termination Date: _____/____/_____	I would like to **Terminate** the following voluntary vision insurance coverage: ☐ Single Coverage ☐ Employee + Child(ren) Coverage ☐ Employee + Spouse Coverage ☐ Family Coverage

SPOUSE AND/OR DEPENDENT INFORMATION:
If you are applying for coverage for your spouse and/or dependent(s) please provide the information requested below:

Put an X if Dep. is a new add to the plan.	Name (First, Middle initial, Last)	Relationship	Date of Birth	Female/ Male	Social Security Number

This Enrollment Form explains the general purpose of the insurance described, but in no way changes or affects the policy(s) actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. The benefit product contains limitations and exclusions, complete coverage information can be found in your Booklet-Certificate if you become insured. Please read it carefully and keep it in a safe place with your other important papers.

ELECTION AND DEDUCTION AUTHORIZATION

I understand by signing this form, I am making a binding election for my benefits. I recognize completion of this form does not guarantee eligibility for a plan. I further understand I may not change my benefit elections except during the annual open enrollment or within 31-calendar days of a qualifying life event or 60 days from birth of a child. In the event of a qualifying life event I understand it is my responsibility to notify Human Resources in writing within 31-calendar days of the qualifying event or 60 days from birth of a child.

Election and Deductions: I hereby apply for the coverages I have checked for myself and my dependents. I authorize City of De Pere to make deductions out of my earnings on a before-tax basis for my contributions to the healthcare, dental, and vision insurance plans. Should my employment terminate, I authorize my employer to make any required payroll deductions associated with my benefits from my final paycheck.

Employee Signature _____ **Date** _____

HRA EMPLOYEE INFORMATION

Enrollment in the Health Reimbursement Account (HRA) is automatic based on your health insurance election. You will receive a DEBIT card (Benny Card) that you can use for the Health Reimbursement Account. If you prefer to receive reimbursement via direct deposit you can complete your direct deposit information online at www.ebcflex.com. Step by step instructions are available in the Benefit Handbook.

General Plan Information

- ✓ City of De Pere's Plan Year renews every **January** and runs for 12 consecutive months
- ✓ HRA's are 100% employer funded reimbursement plans that allow for reimbursement of a specific qualifying medical expense. (Please refer to your Plan SPD for details)
- ✓ After the plan year ends, you have **90 Days** to submit expenses incurred during that plan year.
- ✓ If your employment terminates during the plan year, you will have **90 Days** to submit expenses incurred up to your termination date.
- ✓ Your election will remain in effect for the entire plan year, unless you have a qualifying status change and the change is consistent with the qualifying event.

CC: Payroll

Rev. 12/01/2023