



City of Memphis

ACTIVE EMPLOYEE BENEFITS ENROLLMENT CHANGE FORM AND INSURANCE AFFIDAVIT

NOTE: Complete **ONLY** if you elect to enroll in or change existing coverage. You must elect FSA each year during open enrollment in order to continue enrollment. All other benefits will continue unless you make a change. When completing the form, if you fail to make a selection, we will assume you are waiving the coverage and will not enroll you nor your dependents for that benefit.

EMPLOYEE ACTION (please select one):

Enroll in Benefits Cancel All Benefits Make Changes Add/Delete Dependents

A. EMPLOYEE INFORMATION				
Social Security Number - -	City Oracle ID Number	Last Name M.I.	First Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Street Address		Apt.#	Effective Date of Enrollment/Change:	Division Name
City, State, Zip			Date of Birth:	Hire Date:
Email Address:			Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -	
B. REASON FOR ENROLLMENT/CHANGE				
Check one Reason: <input type="checkbox"/> I am a new hire <input type="checkbox"/> I am enrolling during Annual Enrollment <input type="checkbox"/> There has been a change in my family status (qualifying life event-QLE)* *You must submit this form along with required documentation within 60 days of the event date. Please provide QLE and date of event _____ (Qualifying Life Events: Birth/Adoption, Marriage, Divorce or Legal Separation, Change in spouses employment, death, etc.				
C. BENEFIT ELECTION (CHECK ONE PER BENEFIT)				
Medical Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> VALUE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE <input type="checkbox"/> WAIVE COVERAGE If waived, are you are covered by another plan. Yes or No If yes, please list name of insurance carrier _____		<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + FAMILY	
Dental Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> PRIMARY <input type="checkbox"/> WAIVE <input type="checkbox"/> CANCEL <input type="checkbox"/> NO CHANGE		<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + 1 <input type="checkbox"/> EMPLOYEE + FAMILY	
Vision Plan	ENROLL: <input type="checkbox"/> EXAM & MATERIALS <input type="checkbox"/> MATERIALS ONLY <input type="checkbox"/> WAIVE <input type="checkbox"/> CANCEL <input type="checkbox"/> NO CHANGE		<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + 1 <input type="checkbox"/> EMPLOYEE + FAMILY	
Flexible Spending Accounts (FSA)	HEALTH CARE FSA (\$100-\$2500) <input type="checkbox"/> ANNUAL ELECTION AMOUNT:\$ _____ <input type="checkbox"/> WAIVE/CANCEL COVERAGE		DEPENDENT CARE FSA (\$100-5000) <input type="checkbox"/> ANNUAL ELECTION AMOUNT:\$ _____ <input type="checkbox"/> WAIVE/CANCEL COVERAGE	
Short Term Disability Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE			

BENEFIT ELECTION CONTINUED...

<p>Contributory Life Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required</p>	<p>You may purchase coverage at 1.5 times your annual base salary up to a maximum of \$200,000. <input type="checkbox"/> 1.5 times salary <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE</p>
<p>Contributory Dependent Life -\$10,000 ea. (must enroll in contributory life in order to select dependent life)</p>	<p>\$10,000 ea. (must enroll in contributory life in order to select dependent life) <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN (6 months to 19 years) if student to age 25 <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE</p>
<p>Voluntary Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required</p>	<p>(You may purchase in \$10,000 increments with a guaranteed issue amount of \$200,000 or 3 times your annual salary whichever is less. You will need to complete an evidence of insurability form for any amount above the guaranteed issue amount. We will mail the EOI form to you upon receipt of the enrollment form. Total coverage (guaranteed plus additional) cannot exceed \$500,000 or 5 times your annual salary.) <input type="checkbox"/> Amount Requested:\$ _____ <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE</p>
<p>Voluntary Spouse and Dependent Life (must enroll in voluntary life in order to select dependent life)</p>	<p>You may purchase life insurance for your spouse in increments of \$5000 not to exceed 50% of your elected amount with a guaranteed amount of \$30,000 if you are under age 60. You will need to complete an evidence of insurability form for any amount above the guaranteed issue amount. We will mail the EOI form to you upon receipt of the enrollment form. Total coverage (guaranteed plus additional) cannot exceed \$250,000. <input type="checkbox"/> Amount Requested for Spouse:\$ _____ <input type="checkbox"/> CHILDREN (6 MONTHS TO AGE 19) TO AGE 25 IF FULL TIME STUDENT) <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE <input type="checkbox"/></p>

D. FAMILY MEMBERS TO BE COVERED - List all dependents to be covered. If you do not list a dependent, they will not be covered

LAST NAME	FIRST	M.I.	Social Security Number (Required)	Date Of Birth	Check desired Action			Employer Use Only:
					Medical	Dental	Vision	
Spouse:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:

E. OTHER INSURANCE COVERAGE INFORMATION (PLEASE COMPLETE THE SECTION BELOW)

<p>Do you or any of your covered dependents have other Medical/Medicare coverage that is primary to the City's Medical Plan? Yes or No If Yes, Name of Insured: _____ Place of Employment: _____ Insurance Company: _____ Policy #: _____ Insurance Company Phone #: _____ Insurance Company Address: _____</p>	<p>If covered by Medicare, please check what type(s): <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both A&B Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease Medicare HIC #: _____ Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____</p>
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ACKNOWLEDGEMENT AND AUTHORIZATION:

I, _____, hereby certify under penalty of perjury that the information provided in this application for employee benefits, including social security numbers, addresses, spouse and or dependent child(ren) information, is true and correct. I further acknowledge that I understand that providing false information may subject me to a denial of employee benefits, disciplinary action including termination of employment from City of Memphis. I authorize the release of this information to my employer, the City of Memphis, and insurance carriers. In addition:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions, either prospectively or retroactively, for my elected benefits.
- I agree it is my responsibility to check my earnings statement each month to verify my current benefits enrollments and deductions and to alert Health Wellness and Benefits immediately of any errors. Further, I understand that the City of Memphis may not be able to remedy problems identified beyond 30 days.
- I understand that my benefits can only be changed during the designated annual Open Enrollment period or by written notification to Health Wellness and Benefits within 60 days of a qualified life event.
- I understand it is my responsibility to contact Health Wellness and Benefits within 60 days to remove my ex-spouse from all benefits plans if I divorce or become legally separated.
- I understand that while on an unpaid leave of absence or any unpaid status, I am responsible for paying my benefits premiums. Failure to pay premiums timely may result in cancellation of my benefits and reimbursement of any claims paid to my provider(s) for healthcare, etc.

My signature below indicates I have read and understand the above:

Print Name:	Signature:	Date:	Oracle Employee ID #(Required):

EMPLOYER USE ONLY:

Employee Enrollment Date:	Termination Date:	Employment Status: _Active _COBRA _ NEMP
Received By/Date:	Entered By/Date:	