



Town of Chino Valley 2016-2017 Benefits Election Form

Effective Date _____

Check applicable New Hire Open Enrollment Address Change Name Change Beneficiary Change Mid-Year Enrollment Change
 You may be required to submit a copy of a marriage certificate and/or a birth certificate for each dependent that you enroll in the medical plan.

EMPLOYEE INFORMATION – PLEASE PRINT

NAME _____ M F SSN _____

 Mailing Address _____ State _____ Zip _____

 Telephone _____ Work Telephone _____ e-mail _____
 Date of Birth _____ Marital Status Single Married Date of Hire _____

MID-YEAR ENROLLMENT CHANGES – CHECK ALL THAT APPLY

Family Status Events – Date of Event _____
 Marriage – *copy of marriage certificate required*
 Divorce or Legal Separation – *copy of court papers required*
 Birth or Adoption – *copy of birth certificate and adoption paperwork required*
 Child requires coverage due to QMCSO – *copy of child support order required*
 Loss of child's eligibility reaches maximum age of 26 for medical coverage OR maximum age of 23 for dental/vision coverage
 Death – *copy of death certificate required*
 Covered person has become eligible or ineligible for other medical
 Employment Status Events – Date of Event _____
 Spouse eligible for benefits in another plan – *proof of gain of insurance required*
 Spouse loses employment or becomes ineligible for health benefits – *proof of loss or gain of insurance required*

You must return your completed enrollment form to the HR Department within 31 days of the status event or you will have to wait until the next open enrollment for your change to be effective (07/01/2017).

PLAN ELECTIONS AND MONTHLY COST – EMPLOYEE AND DEPENDENTS MUST ENROLL IN THE SAME PLAN

A. MEDICAL

	Premier Plan	Basic Plus Plan	High Deductible Health Plan
1 Waive Coverage	___ Initial	___ Initial	___ Initial
2 Employee Only	<input type="checkbox"/> \$ 597	<input type="checkbox"/> \$ 365	<input type="checkbox"/> \$ 469
3 Employee & Family	<input type="checkbox"/> \$ 1,145 *	<input type="checkbox"/> \$ 694 *	<input type="checkbox"/> \$ 898 * †

B. DENTAL

	Comprehensive	Preventative
4 Waive Coverage	<input type="checkbox"/> \$ ___ Initial	<input type="checkbox"/> \$ ___ Initial
5 Employee Only	<input type="checkbox"/> \$ 43	<input type="checkbox"/> \$ 15
6 Employee & Family	<input type="checkbox"/> \$ 86 **	<input type="checkbox"/> \$ 29 **

C. VISION

7 Waive Coverage	<input type="checkbox"/> \$ ___ Initial
8 Employee Only	<input type="checkbox"/> \$ 15
9 Employee & Family	<input type="checkbox"/> \$ 31 **

A. Medical Choice \$ _____
 B. Dental Choice \$ _____
 C. Vision Choice \$ _____
 D. Total Monthly Member Cost (A + B + C) \$ _____
 E. Town of Chino Valley Monthly Contribution **\$ (655.00)**
 F. Employee Monthly Salary Reduction (D – E) If less than \$ zero, enter zero _____

* - Family coverage rate reflects a 30% premium reduction, paid by the Town.
 ** - Family coverage rate reflects a 25% premium reduction, paid by the Town.

† - Health Savings Account (HSA):
 If you choose the High Deductible Health Plan, the Town will make the following contributions to your HSA Account:
 Employee Only = \$128.00/month
 Employee & Family = \$128.00/month

If "F" is a negative number, your monthly health insurance premium will be zero.

DEPENDENT INFORMATION – INCLUDE EACH DEPENDENT (SPOUSE AND/OR CHILD(REN) - RELATIONSHIP REQUIRED

Name Last, First, MI	Relationship to You	Date of Birth (MM/DD/YYYY)	SS#	Gender	Action
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change

List any additional dependents on a separate piece of paper

OTHER CREDITABLE COVERAGE – COMPLETE THIS SECTION IF YOU OR YOUR DEPENDENTS ARE ENTITLED UNDER ANOTHER HEALTH PLAN

Are you or any of your dependents entitled to benefits under any other health plan? Yes No

Name of Insured _____

Insurance Company _____ Insurance Company Phone _____

BENEFICIARY INFORMATION

Under Primary Beneficiaries, print your first choice(s) to receive benefits from you basic life and AD&D insurance. Contingent Beneficiaries receive benefits if no primary beneficiaries are living when benefits become payable. List any additional beneficiaries on a separate sheet of paper. Basic life/AD&D insurance only is effective upon you date of hire.

Primary Beneficiaries

Name	Relationship to You	SS#	Percentage of Share
_____	_____	_____	_____
_____	_____	_____	_____

Contingent Beneficiaries

Name	Relationship to You	SS#	Percentage of Share
_____	_____	_____	_____
_____	_____	_____	_____

SIGNATURE – CHECK ALL BOXES THAT APPLY

- I understand that without a qualifying mid-year change event, I will not be permitted to enroll in my employer’s health plan options again until the next annual open enrollment period.
- IF WAIVING ANY COVERAGES:** I understand that I am declining the opportunity to enroll in my employer’s medical plan coverage (that is both affordable and valuable and meets the current standards of the Affordable Care Act), and/or dental plan coverage and/or vision plan coverage and will not be permitted to enroll in my employer’s health plan options again until the next annual open enrollment period without a qualifying mid-year change event.
- IF WAIVING MEDICAL COVERAGE ONLY:** I understand that without medical plan coverage, I could have a penalty applied when filing my personal income taxes (including my dependents, if any).

Employee Signature _____ Date _____

All of the statements I have made on this form are true and accurate to the best of my knowledge. I understand the benefit choices I have made and authorize the Employer to make any payroll deductions required to pay for my benefit choices. I also understand that the pre-tax (salary reduction) choices I have made on this form will remain in effect until the next open enrollment unless I have a qualified family status change (i.e. Marriage, divorce, death, birth/adoption of dependent, or change in employment status of spouse or dependent) as defined by federal law with regard to my elections.

I understand that by waiving coverage, I am declining the opportunity to enroll in my employer’s medical plan coverage that is both affordable and valuable under the current standards of the Affordable Care Act.

- I understand that without a qualifying mid-year event, I will not be permitted to enroll in my employer’s medical plan options again until the next annual open enrollment time.
- I also understand that without medical plan coverage I (and my dependents, if any) could have a penalty applied when I file my personal income taxes.

Please return this completed form to the Human Resources Department before your enrollment deadline.

HR Use Only Last _____ First _____ MI _____ Annual Salary \$ _____ TPA entered _____