# CITY OF FORT SMITH

## 2019 EMPLOYEE BENEFIT SELECTION FORM

***(THIS FORM MUST BE COMPLETED, SIGNED & RETURNED TO HR EVEN IF YOU ARE WAIVING ALL COVERAGES)***

| EMPLOYEE DEMOGRAPHICS | | | | | |
|---|---|---|---|---|---|
| Employee Name: | | | | Employee ID #: | |
| Date of Birth: | | Gender: | | Department #: | |
| Social Security Number: | | | | Phone #: | |
| Street Address: | | | | Apt/Unit #: | |
| City, State, Zip: | | | | Job Title: | |
| Email: | | | | Hire Date: | |
| New Address (*if different*) | | | | | |

| DEPENDENT DEMOGRAPHICS | | | | | |
|---|---|---|---|---|---|
| | Name | Date of Birth | Social Security Number | Gender | Action (Please circle one) |
| Spouse: | | | | | ADD / TERM / NO CHANGE |
| Child: | | | | | ADD / TERM / NO CHANGE |
| Child: | | | | | ADD / TERM / NO CHANGE |
| Child: | | | | | ADD / TERM / NO CHANGE |
| Child: | | | | | ADD / TERM / NO CHANGE |

| 2018 BENEFIT ELECTIONS | | | | | |
|---|---|---|---|---|---|
| Wellness: | | Medical: | | | |
| Dental: | | Vision: | | Voluntary Life: | |
| Dependent Life: | | Critical Illness: | | Accident: | |

**I choose to NOT make any change to my 2019 benefits. ☐ No Change _____Initials**

## 2019 BENEFIT ELECTIONS

### Medical Plan Options

| Plan 1 – $2,000 Deductible | | Plan 2 - $1,250 Deductible | | Plan 3 - $500 Deductible | |
|---|---|---|---|---|---|
| Please check election below | ✓ | Please check election below | ✓ | Please check election below | ✓ |
| Employee Only: | | Employee Only: | | Employee Only: | |
| Employee & Spouse: | | Employee & Spouse: | | Employee & Spouse: | |
| Employee & Child(ren): | | Employee & Child(ren): | | Employee & Child(ren): | |
| Employee & Family: | | Employee & Family: | | Employee & Family: | |
| Decline Coverage: | | Decline Coverage: | | Decline Coverage: | |

| Dental Plan | | | Vision Plan | | |
|---|---|---|---|---|---|
| Please check election below | ✓ | Cost Per Pay Period | Please check election below | ✓ | Cost Per Pay Period |
| Employee Only: | | $ 4.53 | Employee Only: | | $ 0.79 |
| Employee + 1 Dependent: | | $ 9.06 | Employee + 1 Dependent: | | $ 1.54 |
| Employee & Family: | | $ 13.59 | Employee & Family: | | $ 2.27 |
| Waive: | | WAIVED | Waive: | | WAIVED |

| Supplemental Voluntary Life Insurance | | | Supplemental Dependent Life Insurance | | |
|---|---|---|---|---|---|
| Guaranteed Issue Amounts: Employee $200,000 | | | Spouse and Dependent Children: $10,000 each | | |
| Please check elections below | ✓ | Check Desired Multiple of Salary | Please check election below | ✓ | Amount |
| Employee: $0.115 per $1,000 of benefit | | ☐1x ☐2x ☐3x ☐4x ☐5x | Elect: $1.73 per paycheck | | $10,000 |
| Waive: | | WAIVED | Waive: | | WAIVED |

*While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this form and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about your form, please contact Human Resources.*

| Critical Illness | | | | | Accident | | |
|---|---|---|---|---|---|---|---|
| *Max Amounts:* | *Employee - $20k* | *Spouse - $10k* | *Child - $10k* | | Please check elections below | ✓ | Cost Per Pay Period |
| Please check elections below | | ✓ | **Please refer to rate grid for premiums* | | | | |
| | Benefit Amount | | Cost Per Pay Period | | Employee Only | | $8.24 |
| Employee: | ☐$10k ☐$20k | | $ | | Employee & Spouse | | $12.83 |
| Spouse: | ☐$5k ☐$10k | | $ | | Employee & Child(ren) | | $12.63 |
| Child: | ☐$5k ☐$10k | | $ | | Employee & Family | | $17.22 |
| | Waive: | | WAIVED | | Waive: | | WAIVED |

| Flexible Spending Account | | |
|---|---|---|
| Please check election below | ✓ | Enter the **ANNUAL Amount** you want to defer: (ex: $1,500) |
| Medical Flexible Spending Account: | | $ (limited to $2,650) |
| Dependent Care Flexible Spending Account: | | $ (limited to $5,000) |
| Waive FSA: | | WAIVED |

| EMPLOYER PAID BENEFITS |
|---|
| Group Long Term Disability - 60% of Annual Earnings<br>Basic Life Insurance - $100,000 of Benefit |
| **TOBACCO ATTESTATION** |
| In the past 12 months, have you used any form of tobacco (including smokeless, e-cigarettes, and vaping)? ☐ Yes ☐ No |

# DESIGNATION OF BENEFICIARY

As a participant in the **GROUP LIFE INSURANCE PLAN** you will need to complete this form naming the beneficiary(ies) you wish to receive benefits payable in the event of your death.

| Employee Name: | | | |
|---|---|---|---|
| I wish to designate the following individual(s) as primary beneficiary(ies): | | | |
| **Name** | **Date of Birth** | **Relationship to You** | **% Share** (must total 100%) |
| | | | |
| | | | |
| | | | |
| I also wish to designate the following individual(s) as secondary beneficiary(ies) | | | |
| **Name** | **Date of Birth** | **Relationship to You** | **% Share** (must total 100%) |
| | | | |
| | | | |
| | | | |

By signing below, I agree to the elections above for myself and/or dependents for the plan year January 1, 2019 through December 31, 2019. I understand that this election is made on an annual basis and cannot be changed until the next open enrollment period as set forth by the rules and regulations of the IRS Section 125 Cafeteria Plan code unless I incur a qualified life change in family or employment status. I understand that under PPACA (The Patient Protection & Affordable Care Act) waiving coverage in my employer sponsored medical plan for myself and/or my dependents may result in a tax penalty if I and/or my dependents do not have other health coverage.

Employee Signature Date

*While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this form and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about your form, please contact Human Resources.*