



# FY17 BENEFIT ENROLLMENT/CHANGE FORM

<input type="checkbox"/> Change (Reason) _____ (Attach Supporting Documents)		Date of Event:		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <sup>1</sup>	
Last Name:		First Name:		MI:	Date of Birth:
Address (Street)		City	State	Zip Code	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Date of Hire:		SSN:	Address Change YES NO		
Email Address:		<b><i>No New Enrollments Into HMO</i></b>			

### MONTHLY COSTS

MEDICAL PLAN (BCBSAZ Administered)	PPO	<input type="checkbox"/> Employee Only.....Cost: \$60.39 <input type="checkbox"/> Employee + 1.....Cost: \$220.74 <input type="checkbox"/> Employee + Family...Cost: \$353.55	HMO	<input type="checkbox"/> Employee Only.....Cost: \$60.39 <input type="checkbox"/> Employee + 1.....Cost: \$232.10 <input type="checkbox"/> Employee + Family...Cost: \$369.46	Decline <sup>2</sup>	Cancel	No Change
I have secondary medical insurance <input type="checkbox"/> yes <input type="checkbox"/> no							
DENTAL PLAN (METLIFE Administered)	PPO	<input type="checkbox"/> Employee Only.....Cost: \$4.67 <input type="checkbox"/> Employee + 1.....Cost: \$15.83 <input type="checkbox"/> Employee + Family...Cost: \$33.30			Decline	Cancel	No Change
VISION PLAN (AVESIS Administered)		<input type="checkbox"/> Employee Only.....Cost: \$0.00 <input type="checkbox"/> Employee + Family...Cost: \$3.65			Decline	Cancel	No Change
GROUP LIFE INSURANCE (STANDARD <sup>4</sup> ) <i>Additional Form Needed*</i>		<input checked="" type="checkbox"/> Basic.....Cost: \$0.00 <small>(Coverage = 2x Salary)</small>		<input type="checkbox"/> Dependent Coverage.....Cost: \$3.04 <small>(Coverage = \$5,000/Child &amp; \$10,000/Spouse) *Children up to age 21 or up to age 25 if FT student</small>	Decline	Cancel	No Change
PENSION PLAN (ASRS/PSPRS <sup>5</sup> )		I have retired from ASRS: <input type="checkbox"/> yes <input type="checkbox"/> no		I have retired from PSPRS: <input type="checkbox"/> yes <input type="checkbox"/> no			

***\*THE FOLLOWING PLANS REQUIRE AN ADDITIONAL FORM FROM THE CARRIER/PROVIDER***

SUPPLEMENTAL RETIREMENT SAVINGS PLAN <i>Online Action Needed Additional Form Needed</i>	Plan	Deduction Per Pay Period		Decline	Cancel	No Change	
	<input type="checkbox"/> Nationwide 457(b)	ONLINE	ONLINE				
	<input type="checkbox"/> ASRS/Nationwide 401(a) <sup>3</sup>	_____% <small>Select Increments of 0.5%</small>	\$_____ <small>Enter per pay period \$ amount (\$10.00 min.)</small>				
VOLUNTARY TERM LIFE INSURANCE (METLIFE <sup>5</sup> ) <i>Additional Form Needed</i>	Employee Only Coverage Requested (increments of \$10,000) \$_____ Coverage over \$120,000 (or 3x annual salary, whichever is less), requires a <b>Statement of Health Form</b> (max coverage allowed \$500,000 or 5x annual salary, whichever is less)	Spouse Coverage Requested \$_____ Coverage over \$40,000 requires a <b>Statement of Health Form</b> (max coverage allowed \$100,000)	Dependent(s) Coverage Amount: \$25,000 children 6 mos. or older (up to age 19, or 23 if a FT student) \$1000 children under 6 mos. Cost: \$3.43	Decline	Cancel	No Change	
SUPPLEMENTAL COVERAGE (AFLAC) <i>Additional Form Needed</i>	<input type="checkbox"/> Specified Health Event <input type="checkbox"/> Accident Indemnity <input type="checkbox"/> Cancer Indemnity <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Disability Income Protection			NOTE: Coverage is not guaranteed and is subject to approval by AFLAC			
FLEXIBLE SPENDING ACCOUNT (Health Equity) <i>Additional Form Needed</i>	<input checked="" type="checkbox"/> Medical Expense Election \$100 Min/\$2,550 Annual Max (07/01-06/30) Amount Per Pay Period: \$_____		<input checked="" type="checkbox"/> Dependent Care Election \$100 Min/\$5,000 Annual Max (07/01-06/30) Amount Per Pay Period: \$_____		Decline	Cancel	No Change

### DEPENDENT INFORMATION (For Employee +1 or Family plans, list all dependents, type of coverage, and action requested)

Name (Last, First, MI)	Relationship <small>SP=Spouse CH=Child DP=Domestic Partner DPC= Domestic Partner's Child</small>	DOB	Sex M/F	Social Security Number <b>REQUIRED</b>	Add or Remove Dependents <b>A=Add / R=Remove / NC= No Change</b>			
					Medical	Dental	Vision	Standard

<sup>1</sup> Must submit Domestic Partnership Affidavit form. Benefits available for health, dental and vision coverage only. <sup>2</sup> **MEDICAL OPT OUT** – If opting out, an employee can only re-enroll during open enrollment or if there is a qualifying change in status. Must provide proof of other insurance coverage. Employee will receive opt-out pay of \$100.00 monthly. If both employee and spouse are City employees, they are not eligible for the opt-out pay. **Must Attach Right of Refusal Form.** <sup>3</sup> Must be Fulltime Regular Employee within 2 years of your date of hire and at least 30 years of age at time of enrollment. <sup>4&5</sup> Coverage is not guaranteed and subject to approval by Standard and/or MetLife

I hereby apply for group benefits for which I am eligible under the City of Surprise group plan(s) and authorize that the appropriate payroll deductions, if required, be deducted from my earnings. I have carefully read all the forms and been given information that explains the terms and conditions of this coverage. On behalf of myself and the person(s) listed as eligible dependent(s) on the enrollment form(s), I apply for enrollment and/or waive group benefits subject to all terms and conditions of each carrier offered by my employer.

Signature: _____	Date: _____
HR USE ONLY	
<input type="checkbox"/> BCBSAZ Admin'd <input type="checkbox"/> Avesis <input type="checkbox"/> HealthEquity FSA <input type="checkbox"/> COBRA <input type="checkbox"/> HIPAA Receipt <input type="checkbox"/> PEHP Election <input type="checkbox"/> ACR – ASRS/PSPRS	<input type="checkbox"/> Standard <input type="checkbox"/> MetLife Dental <input type="checkbox"/> MetLife Life <input type="checkbox"/> ASRS/PSPRS <input type="checkbox"/> PDS Vista Input <input type="checkbox"/> AFLAC
Effective Date*: _____	