CITY OF IRVING OPEN ENROLLMENT INSURANCE CHANGE FORM

SECTION 1 GENERAL INFORMATION

EMPLOYEE

Name (Last)	(First)	(M.I.)	Social Security #

Address	(City)	(State)	(ZIP Code)	(County)

Home Phone ( )	Dept. #	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Sex ☐ Female ☐ Male

SPOUSE (for coordination of benefits)

Name (Last)	(First)	(M.I.)	Social Security #

SECTION 3 SELECTION OF HEALTH, DENTAL, VISION AND HYATT LEGAL BENEFITS

I am not making changes to my coverage for these plans for 2017 ☐ , or:

- Complete Section 3A; *provide information in 3B – 3E only where enrollment/change applies.*
- Eligibility documentation must be provided to HR for any dependents being added for the first time.

Line numbers below and in Health, Dental and Vision tables correspond to:
Line 1: Employee (if not applicable, leave line blank)
Line 2: Spouse (if not applicable, leave line blank)
Lines 3-7: Eligible dependents

3A PERSON(S) ELIGIBLE FOR COVERAGE

	Name	Social Security	Birth Date	Sex	Relationship
1	Employee:				Self
2	Spouse:				Spouse
3	Dependent:				
4	Dependent:				
5	Dependent:				
6	Dependent:				
7	Dependent:				

3B HEALTH (CIGNA)

SELECTION ☐ Choice Local Plus ☐ Quality OAP ☐ Quality Connect OAP

	Option (see list)
1	
2	
3	
4	
5	
6	
7	

SECTION 4

NOTE: To participate in FLEX SPENDING or a HEALTH SAVINGS ACCOUNT, a new form must be completed and submitted annually.

INSURANCE COVERAGE WAIVER The City of Irving has offered me group coverage for Health, Dental and Vision Insurance benefits. After seriously considering the benefits, I have decided *not* to enroll myself or any dependents in:

☐ Health (see below) ☐ Dental ☐ Vision

HEALTH INSURANCE OPT-OUT I understand that the Patient Protection and Affordable Care Act (PPACA) requires employers to provide medical insurance for employees. Employers must also maintain annual data on all employees and eligible dependents. I have decided to opt out of the health insurance offered. I have medical coverage through:

☐ Spouse ☐ Parents ☐ The Health Care Exchange ☐ None (no medical coverage)

SECTION 2 QUALIFYING EVENT / REASON

OPEN ENROLLMENT CHANGE DATE: January 1, 2017

AFLAC enrollments, cancellations and changes must be done by the vendors' representatives.

OPTION CODE LIST

Enter appropriate code in tables below for each enrollment / change

E = Enroll / add dependent

T = Terminate coverage / drop dependent

C = Convert to new plan or coverage level

LIFE INSURANCE

Increases greater than the 3x or 2-step increase limit must have an Evidence of Insurability (EOI) form completed and approved by CIGNA before the change will become effective.

Separate life insurance change and EOI forms must be completed and submitted for any change.

SECTION 3 Continued

3C DENTAL (CIGNA)

SELECTION ☐ Dental HMO ☐ Dental PPO ☐ Dental PPO Buy-Up

	Option (see list)	Dentist Selection (Required for Dental HMO plan)
1		Dentist Name ID Number
2		Dentist Name ID Number
3		Dentist Name ID Number
4		Dentist Name ID Number
5		Dentist Name ID Number
6		Dentist Name ID Number
7		Dentist Name ID Number

3D VISION (NVA)

Offered by
National Vision Administrators

ENTER OPTION CODE (SEE LIST)

	Standard Option	Buy-Up Option
1		
2		
3		
4		
5		
6		
7		

3E LEGAL SERVICES

Offered by
Hyatt Legal Services

CHECK APPROPRIATE BOX

☐ Enroll in Hyatt Legal

☐ Cancel Hyatt Legal

Selection needed only if making a change.

☐ Cancel Pre-Paid Legal

SECTION 5 AUTHORIZATION

I have read this form and the other materials provided to me about my City of Irving benefits, and certify the information supplied is correct to the best of my knowledge. I hereby apply for coverage provided by the City's group benefit plans, and authorize the City to deduct any necessary coverage contributions from my earnings for the coverage requested, and any licensed dentist, physician, hospital or other health care provider to furnish the plan administrator with dental or medical information about myself or my eligible dependents, as permitted by law. I accept the plan provisions, and understand I am responsible for any charges not covered by the plans, and that my coverage may be affected by failure to provide complete, accurate and timely information.

Subscriber's Signature **Date**