INSURANCE ENROLLMENT/DECLINATION FORM INSTRUCTIONS

(Health, Dental & Vision)

The health/dental/vision coverage is available on the first of the month following or coinciding with 60 days from the date of hire. An initial enrollment form is required within (31) days of the employee becoming eligible for coverage.

SECTION 1 - ENROLLMENT REASON

Check the applicable box(es) relating to the enrollment reason.

SECTION 2 - EMPLOYEE INFORMATION

This section must be completed to provide us with your basic personal information.

SECTION 3 – MEDICAL ELECTION or DECLINATION OF COVERAGE

MEDICAL ELECTION - This section must be completed IF YOU ARE ELECTING MEDICAL COVERAGE.
Please select which medical plan and coverage (single or family) you are electing.
All Units & Non-Bargaining – May choose to elect either the $500 Plan or $750 Plan.

Please see the Health Plan Designs & Employee Costs for the group plan SPDs and for your monthly premium amount.

DECLINATION OF COVERAGE - This section must be completed IF YOU ARE DECLINING MEDICAL COVERAGE at this time **for yourself or any eligible dependents.** You must also note whether the individuals have coverage from another source.
IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER FOR A SPECIAL ENROLLMENT PERIOD AS DESCRIBED ON PAGE 2 OF THE INSURANCE ENROLLMENT FORM TO APPLY.

SECTION 4 – DENTAL ELECTION or DECLINATION OF COVERAGE

This section must be completed for your dental coverage election or declination of coverage. If electing dental coverage, checkmark either the Basic Plan or Buy-Up Plan, and then checkmark either Single coverage or Family coverage. If declining coverage, only checkmark the box to decline coverage. The Buy-Up Dental Plan is an enhancement to the BASIC Dental Plan.
Note: Your dental monthly premium is based on your medical election/declination.

Please see the Dental Flyer for the group plan SPDs and for your monthly premium amount.

SECTION 5 – VISION ELECTION or DECLINATION OF COVERAGE

This section must be completed for your vision coverage election or declination of coverage. If electing vision coverage, checkmark either the Single coverage or Family coverage. If you wish to decline the vision coverage, check the declination box.
Please see the Vision Brochure for the group plan SPD and for your monthly premium amount.

SECTION 6 - DEPENDENT INFORMATION

This section must be completed only if you are electing family coverage for medical, dental and/or vision OR removing an eligible dependent (spouse/child). List all dependents (spouse and dependent children) for whom you are electing coverage. List additional dependents on an attached sheet. Note: Enter "A" for Add or "R" for Remove under the (H)ealth,(D)ental,(V)ision columns for each dependent. Attach copies of custody decrees or Qualified Medical Child Support Order. If you have dependent children over the age of 26, you must complete a dependent eligibility verification form and a Certification of Dependent Child Tax Status Form. Please contact Human Resources.

SECTION 7 - SPOUSE INFORMATION (Complete only if requesting coverage for spouse)

Complete this section only if you are requesting coverage for your spouse.

SPECIAL ENROLLMENT PROVISION & DEPENDENT BENEFICIARIES

Enrollment or changes to medical, dental and/or vision insurance typically will take place when hired (if eligible) and each year during the open enrollment period. However, certain events may qualify outside the open enrollment period to enroll or decline coverage for you or your eligible dependents.

AGREEMENT, ASSIGNMENT, and AUTHORIZATION

Please read and sign this section. This section must be signed in order to process the enrollment request. ONLY sign this section if you understand and authorize monthly premiums to be taken as an after-tax deduction. You need to sign either section 9 or 10, not both.

If you have questions or need additional information on benefits please contact the Black Hawk County Human Resources Office at (319) 833-3009.