THE CITY OF DULUTH MINNESOTA

Health & Dental Benefits Enrollment / Change Form

Human Resources
Room 340
411 West First Street
Duluth, Minnesota 55802

Benefits Effective Date: _____

First Payroll Deduction: _____

You have 31 days from your date of hire or from the *"Date of Event"* listed under the *"Reason for Enrollment or Change"* section to complete and submit this form to the City of Duluth's Human Resources Office. Once you complete and submit this form, it will be recorded as your election until the next Open Enrollment. You will not be able to make changes to your enrollment elections unless you have a qualified status change.

SECTION A: Employee Information

Clear Section A

Full Name: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of Birth: _____

Department: _____ Date of Hire: _____

Division: _____ Bargaining Unit: ☐ Not Represented (NREP) ☐ Basic ☐ LELS ☐ Confidential ☐ Police ☐ Supervisory ☐ Fire

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated

Status: ☐ Full-Time ☐ Part-Time (Hours/Week: _____)

SECTION B: Reason for Enrollment or Change

Clear Section B

☐ New Employee

Date of Hire: _____

Check all that apply: *Documentation is required for all qualifying status-change events*

☐ Birth/Adoption
☐ Marriage
☐ Divorce/Annulment
☐ Death
☐ Change in employment status (e.g., a change affecting eligibility for health and/or dental benefits)
☐ Spouse and/or child loses other coverage
☐ Child is ineligible (refer to "Dependent Eligibility Requirements")
☐ Judgment or decree (i.e., Qualified Medical Child Support Order or Legal Guardianship)
☐ Other reason (please list): _____

Date of Event: _____

SECTION C: Health Plan Election – Comprehensive Hospital / Medical Benefit Plan

Clear Section C

Coverage Election: ☐ Single ☐ Family *(Full-Time Employees Only)*

☐ I decline health care coverage and have enclosed proof of other health care coverage, which meets the Minimum Essential Coverage (MEC) requirement under the Affordable Care Act.

SECTION D: Dental Plan Election

Clear Section D

Dental Plan Election: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child ☐ Family ☐ Waive Dental *(Part-Time Employees Only)*

Coverage Election: ☐ Low Option - $1,000 Annual Benefit ☐ High Option - $2,000 Annual Benefit

FOR INTERNAL USE ONLY: Health Group # _____ Dental Group # **000405-** _____

Date: _____ Medica: _____ Delta Dental: _____ PERA Life: _____

Payroll: _____ New World: _____ 121 Benefits QB: _____ Deferred Comp: _____

Auditor: _____ MN Life: _____ 121 Benefits SPM: _____ Flex Spending: _____

SECTION E: Dependent Information

Clear Section E

Complete this section if you wish to add or cancel dependent coverage. For qualifying status-change events, please attach supporting documentation.

Full Name of Dependent	Social Security Number	Date of Birth	Gender	Relationship to Employee	Health	Dental
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel

Clear Section F

SECTION F: Additional Insurance Information – Medicare, Medicaid, or Other Coverage

Complete this section and attach a copy of the insurance card(s) if you or any covered dependents are eligible for Medicare, Medicaid, or other insurance.

Full Name of Insured	Coverage Type (Medicare, Medicaid, or other insurance)	Policy Number	Medicare Part A Effective Date	Medicare Part B Effective Date

SECTION G: Authorization and Signature

Clear Section G

I hereby certify by my signature on the enrollment form that the foregoing information provided by me is true and correct, and that I have read and accept the conditions described in the enrollment material. I acknowledge having read the information provided to me and agree to all of the terms as defined by the plans I have selected, and I authorize the required deduction (if any) from my wages. By signing this form, I attest that I have reviewed the "Dependent Eligibility Requirements" and that the information I am submitting is true and accurate. I understand that providing false information or omission of relevant information on this form may result in the denial of claims, cancellation or rescission of coverage, and the City of Duluth or Duluth Joint Powers Enterprise Trust may be required to take action to recover funds expended due to fraud or fiscal misconduct. I also understand that it is my duty to notify the City of Duluth Human Resources Office of any changes provided by me on this form, including changes to the eligibility status of my dependents.

Employee Signature	Date

A family status change is a personal event that warrants a review of employee benefits. The summary below explains how your benefits may be affected and the actions you should take for the following family status change events:

- Marriage, Divorce, Annulment
- Child's loss of eligibility for coverage
- Death of an eligible family member
- Entitlement to Medicare or Medicaid
- Judgment or decree (i.e., Qualified Medical Child Support Order)
- Birth, Adoption or placement for adoption, Gain or Loss of a stepchild or legal ward to your family
- Change in employment status (gain or loss of employment or a change that affects health and dental benefit plan eligibility)

Plan Requirements for Submitting Your Enrollment Change Request If you experience a qualifying family status change event, you can enroll or remove family members from your health and/or dental coverage, or make a change to your current Flexible Spending Account election within 31 days from the date of the event (e.g., the day you marry, the birth date of your newborn child, etc.). Human Resources must receive your benefit election change request within 31 days from the date of the qualifying family status change. If you miss the 31-day window for submitting your enrollment forms, you must wait until the Open Enrollment period to change your benefit elections.

"Consistency Rule" For an election change to be permitted, a qualifying event must have occurred and the election change request must be consistent with the event. For example, if you have single health and dental coverage and you subsequently get married you may add your spouse to your health and/or dental coverage within 31 days from the date you marry.

Dependent Eligibility Requirements

Your family members may be covered under the Duluth JPE Trust sponsored health and welfare benefit plans as long as they meet the eligibility requirements:

Spouse — Legally married or legally separated spouse, or Dependent Child — Birth through age 25 (up to the child's 26th birthday):

- An eligible child can include your unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild or any other child who state or federal law requires be treated as a dependent.
- A grandchild you claim as an exemption on your federal income tax return and who is financially dependent upon you.
- A child of the employee who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO).

Employee Responsibility for Completing Forms

When a qualifying family status change event occurs, you are responsible for completing the benefit enrollment form(s) to:

1.) Add or cancel dependent medical and/or dental coverage;
2.) Make changes to your Flexible Spending Account (medical and/or dependent daycare);
3.) Make changes to your life insurance coverage, beneficiary election, PERA Pension Benefit, and/or Deferred Compensation Plan(s).