City of Fond du Lac
2021 OPEN ENROLLMENT

ELECTIONS DUE BY 12/8/2020

The 2021 Open Enrollment period will extend November 12 – December 8, 2020. Please complete the elections below for health insurance, the flexible benefit cafeteria plan, dental insurance and vision insurance. Find supporting documentation in the Open Enrollment e-Binder or online at: www.fdl.wi.gov/hr/employee-resources/benefits/. Reach out to Human Resources with any questions.

EMPLOYEE INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____
Address: _____ City, State, Zip: _____
Phone Number: _____ Dept./Division: _____
Email Address: _____

A. HEALTH INSURANCE

a. Select only one of the following options:

☐ I choose to enroll in the **Employee Only** coverage. *(Continue to section b)*
☐ I choose to enroll in the **Family** coverage. *(Continue to section b)*
☐ I choose to **waive** City of Fond du Lac health insurance coverage. *(Continue to section c)*

b. Do you or any family member currently have other health coverage? *(If yes, provide information below)*

☐ Yes, Single ☐ Yes, Family ☐ No *(Continue to section c)*

Name of Policy Holder: _____ Employer: _____
Insurance Name: _____ Plan Number: _____

c. Enrollment signature:

ENROLLING IN HEALTH INSURANCE COVERAGE

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover all contributions for coverage.

Signature: Date:

OR

WAIVING HEALTH INSURANCE COVERAGE

I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. I freely and voluntarily waive all health insurance coverage noted above.

Signature: Date:

B. FLEXIBLE BENEFIT CAFETERIA PLAN (SECTION 125)

a. Select only one of the following options:

☐ I choose to **elect**. *(Continue to section b)*
☐ I choose to **waive**. *(Continue to section d)*

b. Annual Election Amounts:

Unreimbursed Medical/Dental/Vision: _____ (Annual Max $2,750)
Dependent Care: _____ (Annual Max $5,000)

***For direct deposit, you must complete the form found in the e-Binder or visit the HPS portal.**

c. Automatic Rollover Election – only allowed if you elect health insurance through the City of Fond du Lac AND nobody in your family has additional insurance. Note: claims for dependents over 18 years of age will not automatically rollover and will need to be manually submitted.

If you elect automatic rollover, the claims that go to HPS can automatically be "rolled over" into your flex plan as an automatic claim under Flex for out-of-pocket amounts: deductibles, copays, coinsurance, etc.

☐ Yes, elect automatic rollover ☐ No, I will submit my claims

d. Enrollment signature:

ENROLLING IN THE FLEXIBLE BENEFIT CAFETERIA PLAN

I hereby authorize the City of Fond du Lac to reduce my gross monthly wages on a pre-tax basis by the amounts stated for the expense period (Jan 1, 2021 – March 15, 2022). Each of the amounts indicated are reimbursable and satisfy the requirements of the Section125 Flexible Benefit Plan.

Signature: Date:

OR

WAIVING THE FLEXIBLE BENEFIT CAFETERIA PLAN

I acknowledge that I have been informed of the above reference plan. I hereby elect not to participate.

Signature: Date:

C. DENTAL INSURANCE

a. Select only one of the following options:

- ☐ I choose to enroll in the **Employee Only** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Employee & Spouse** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Employee & Child(ren)** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Family** coverage. *(Continue to section b)*
- ☐ I choose to **waive** dental insurance coverage. *(Continue to section c)*

b. I want to elect coverage with:

- ☐ Care Plus
- ☐ Delta Dental

c. Enrollment signature:

ENROLLING IN DENTAL INSURANCE COVERAGE

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance.

Signature: Date:

OR

WAIVING DENTAL INSURANCE COVERAGE

I freely and voluntarily waive all dental insurance coverage noted above.

Signature: Date:

D. VISION INSURANCE

a. Select only one of the following options:

- ☐ I choose to enroll in the **Employee Only** coverage.
- ☐ I choose to enroll in the **Employee & Spouse** coverage.
- ☐ I choose to enroll in the **Employee & Child(ren)** coverage.
- ☐ I choose to enroll in the **Family** coverage.
- ☐ I choose to **waive** vision insurance coverage.

b. Enrollment signature:

ENROLLING IN VISION INSURANCE COVERAGE

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance.

Signature: Date:

OR

WAIVING VISION INSURANCE COVERAGE

I freely and voluntarily waive all vision insurance coverage noted above.

Signature: Date:

DEPENDENT INFORMATION – REQUIRED

Legal Marital Status: ☐ Married ☐ Not Married

Name (First & Last)		Social Security Number	M / F	Birth Date (MM/DD/YY)	ENROLL IN: Health (Y/N)	Dental (Y/N)	Vision (Y/N)
Employee:							
Spouse:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							

CERTIFICATION INFORMATION

A. I certify that all of the above information is true and correct. I understand that elected coverages will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make until the plan's next open enrollment period or I meet the exceptions allowed under law. *(i.e. qualifying life event)*

B. I authorize deductions from my earnings for the amounts required, if any, to cover any/all contributions for coverage.

C. Specific to the Flexible Benefit Cafeteria Plan (Section 125). I understand that:

   a. If at the end of the expense period, the total declared reduction in compensation exceeds the substantiated expenses, the IRS requires that any unused amount become the property of the employer and may not be paid to me in cash or used to provide benefits in a later plan year.

   b. I can no longer deduct these expenses from my individual State and Federal income tax returns since they will be paid with non-taxed income.

   c. I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have changes in family status or the City of Fond du Lac determines I meet the exceptions allowed under law to permit a change or revocation of an election.

   d. The City of Fond du Lac will deduct any additional premiums during the plan year if my fixed premium amounts increase.

   e. The City of Fond du Lac may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it is believed advisable in order to satisfy certain provisions of the IRS Code.

   f. This reduction in my taxable wage base will reduce my wages for Social Security purposes and may reduce Social Security benefits to be paid at death, retirement, or disability. I agree to hold harmless the Administrator and its representatives for any loss of Social Security Benefits, which is a result of participation in the Section 125 Plan.

Signature: _____ **Date:** _____