City of Fond du Lac

2023 Enrollment Election Form

For coverage effective _____ **Due Back:** _____

EMPLOYEE INFORMATION

Name: _____

Address: _____ **Phone Number:** _____

_____

Location: ☐ General ☐ AFSCME Transit Police Supervisor ☐ Police ☐ Police Supervisor ☐ Fire ☐ Fire Supervisor

Legal Martial Status: ☐ Married ☐ Not Married

DEPENDENT INFORMATION

Name	Gender (M/F)	Relationship (Spouse/Child)	Date of Birth MM/DD/YYYY	Social Security Number	Enroll In: Health (Y/N)	Dental (Y/N)	Vision (Y/N)	Voluntary Life (Y/N)	Accident (Y/N)	Critical Illness (Y/N)	Hospital (Y/N)

If additional children, please put on a separate sheet

All Rates are Monthly

DEDUCTIONS

Benefit	Options	Enrollment		Monthly Deductions HRA	Monthly Deductions No HRA
Medical	☐ Enroll ☐ Waive	**Auxiant**	☐ Full Time Employee	$ 116.00	$ 165.00
			☐ Full Time Family	$ 301.00	$ 430.00
			☐ Part Time Employee	$ 116.00	$ 165.00
			☐ Part Time Family	$ 1,438.00	$ 1,488.00

Monthly rates could be different based upon union contract.

If electing coverage, do you or any family member have other health coverage? (If yes, provide information below)

☐ Yes, Employee ☐ Yes, Family ☐ No Other Coverage

Name of Policy Holder _____ Who is covered: _____

Relationship to Policy Holder: _____ Policy Holder Date of Birth: _____

Dental	☐ Enroll ☐ Waive	**Care Plus Dental**	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	$ 39.98 $ 79.96 $ 89.20 $ 147.80
		Delta Dental	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	$ 51.96 $ 105.84 $ 115.72 $ 192.06
Vision	☐ Enroll ☐ Waive	**Delta Vision**	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	$ 6.24 $ 12.48 $ 12.74 $ 18.98
Flexible Benefit Cafeteria Plan (Section 125)	☐ Enroll ☐ Waive	**Auxiant**	☐ Unreimbursed Medical/Dental/Vision Coverage Amount: $ _____ Annual Max $3,050 ☐ Automatic Rollover* * 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 automtic 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.	
			☐ Dependent Care Coverage Amount: $ _____ Annual Max $5,000	

Life and AD&D *Beneficiaries can be changed at any time*	☒ Enroll	☒ Employee 1.5x Salary up to $250,000 Exempt 1x Salary up to $150,000 General & Union	☒ Spouse $ $10,000	☒ Child(ren) $ $5,000
Voluntary Life AD&D with Dependents Complete EOI form if increasing amount Beneficiaries can be changed at any time	☐ Enroll ☐ Waive	☐ Employee Coverage Amount: $ _____ Rate _____ See rate sheet	☐ Spouse Coverage Amount: $ _____ Rate _____ See rate sheet	☐ Child(ren) Coverage Amount: $ _____ Rate $5,000 is $1.80 for all children $10,000 is $3.60 for all children
Voluntary Accident	☐ Enroll ☐ Waive	**The Hartfod**	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	$ 6.36 $ 10.02 $ 10.62 $ 16.72
Voluntary Critical Illness	☐ Enroll ☐ Waive	☐ $10,000 ☐ $20,000 ☐ $30,000	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	$ _____ See rate sheet
Voluntary Hospital Indemnity	☐ Enroll ☐ Waive	**The Hartford**	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	$ 10.10 $ 20.84 $ 18.96 $ 31.04

I am authorizing my employer to deduct from my earnings the amounts listed above. In the event of a rate change, I authorize a corresponding change in the amount deducted from my earnings. I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a qualifying event, permitted by my employer and the insurance carrier. I will be offered the opportunity to add, drop, or change coverage at the next open enrollment (currently set for January 1st of each year), which is subject to change by my employer. I understand that if I do not complete and return a new election/open enrollment form at that time, benefit plans or policies currently in effect will continue if allowed.

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 a Life Qualifying Event that meets 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.

Specific to the Voluntary Accident, Critical Illness and Hospital Indemnity insurance.
a. Accident, Critical Illness, and Hospital Indemnity insurance is a supplement to Halth Insurance and is not a substitute for major medical coverage. This is not qualifying health coverage ("minimum essential coverage") that satisfies the health coverage requirement of the Affordable Care Act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes.
b. Accident, Critical Illness, and Hospital Indemnity is a limited benefit health coverage policy and is not a substitue for major medical coverage. Lack of major medical coverage (or other minimum essentail coverage) may result in an additional payment with your taxes.
c. Hospital Idemnity is HSA Compatible. If you (or your dependent(s)) currently participate in a Health Savings Account (HSA) or if you plan to do so in the future, you should be aware that the IRS limits the types of supplemental insurance you may have an addition to a HSA, while still maintaining the tax-expempt status of the HSA> The IRS allows additional insurance that provides benefits for "a fixed amount per day (or othe rperiod) of hospitalization." If you participate in an HSA, you should only enroll for a hospital indemnity (HI) plan that is designated as HSA compatible. In any circumstance, if you participate in an HSA, we encourage you to consult with your tax advisor for help eith making informed decisions about your supplemental health coverage.

Employee Signature _____ Date _____

Employee Name *(please print)* _____

Please provide completed forms to Nikki Willner in HR