

## 2018 City of Bowling Green – Medical and Dental Election Form

**PLEASE MARK WHICH APPLIES TO YOU AND FOLLOW THE INSTRUCTIONS:**

**New Hire –**  
Complete all sections

**Open Enrollment with no changes –**  
Complete **highlighted** sections

**Open Enrollment with changes –**  
Mark changes only

**Employee Information (please print clearly)**

<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>
<b>Address:</b>	<b>Social Security #:</b>	<b>Date of Birth:</b>
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Daytime Phone Number:</b>	<b>Evening Phone Number:</b>	<b>Gender:</b>
<b>Marital Status: (Single, Married, Divorced, Widowed)</b>	<b>Hire Date:</b>	<b>Other Medical Coverage: (Y/N):</b>

**Dependent Information (Add/Drop)**

Add or Drop	Name (Last, First, Middle Initial)	Social Security # (Required for Spouse)	Date of Birth	Gender
	Spouse			
	Child			
	Child			
	Child			

**Member Election Information**

	Aetna Standard Plan #3 Medical Plan	Aetna Dental Plan
<b>Single</b>	<input type="checkbox"/> \$	<input type="checkbox"/> \$
<b>Employee + Spouse</b>	<input type="checkbox"/> \$	<input type="checkbox"/> \$
<b>Employee + Child(ren)</b>	<input type="checkbox"/> \$	<input type="checkbox"/> \$
<b>Family</b>	<input type="checkbox"/> \$	<input type="checkbox"/> \$
<b>Waiver of Coverage</b>	<input type="checkbox"/> Waiving Medical Coverage	<input type="checkbox"/> Waiving Dental Coverage

**ELECTION & DEDUCTION AUTHORIZATION:**

I understand that by signing this form, I am making a binding election for my benefits for the period \_\_\_\_\_ through December 31, 2018. I further understand that I may not change my benefit elections unless the changes are a result of a qualifying event (e.g., marriage, divorce, birth or adoption, death of a dependent, or change in my spouse's employment status that affects my spouse's benefits eligibility under another employer's plan). **NOTE: If you experience a qualifying event, you must notify Human Resources within 30 days of your status change.**

By signing this form, I verify that all the information I provided on this enrollment form is true and correct to the best of my knowledge, and that I have received all required employer notices.

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Premium Conversion Election** My signature authorizes my employer to reduce my annual compensation during the Plan Year on a pre-tax basis to pay for my share of the premium for those benefits for which I have enrolled. See reverse side for details.

**NOTE: Your share of the premium will automatically be deducted from your paycheck on a pre-tax basis unless you indicate otherwise below.**

**Premium Conversion Election Form and Salary Reduction Agreement**

You may elect to have your share of premiums under certain employer-sponsored Benefit Plan(s) paid with pre-tax dollars under the Premium Conversion Plan (the "Plan"). Your compensation will be reduced before taxed to pay your share of the premium. If you do not want to pay your premium with pre-tax dollars, or if you fail to return the Election Form on time, and you are enrolled for benefits under the Plan(s), your share of the premium will be paid outside the plan using after-tax dollars that will be deducted from your pay. Please indicate in Section I if you wish to elect this after-tax option.

**Irrevocable Election.** Once you are enrolled in the pre-tax election, you cannot change or revoke your election until the open enrollment period for the next plan year unless you experience a qualifying event (e.g., marriage, divorce, birth or adoption, death of a dependent, or change in my spouse's employment status that affects my spouse's benefits eligibility under another employer's plan). The election change must be requested within 30 days of the event.

**SECTION 1:**

\_\_\_\_\_ I wish to change my automatic pre-tax election as described on the reverse side of this form. I understand that as of 1/1/2018, my share of the premium will be paid for using after-tax dollars. I further authorize the appropriate after-tax payroll deductions.

**Employee Statement:** I understand that the execution of this Salary Reduction Agreement does not enroll me for coverage under the health care benefit plans or policies, and that pre-tax premiums paid under this agreement reduce my compensation for Social Security tax purposes. My election on this Form revokes any prior election under the Plan. Before the beginning of each plan year, I will be offered the opportunity to change my election. If my contribution for the benefit plan(s) is increased or decreased during the Plan Year, I authorize the Plan Administrator to adjust my salary reductions to cover my share of the premium.