OPEN ENROLLMENT FOR PLAN YEAR 2011

CITY OF VENICE GROUP INSURANCE

Read instructions & important information on reverse. *Please type or print firmly with black ink.*

PERSONAL INFORMATION

Last Name	First Name	Middle Initial
Mailing Address Apt. Number		
City	State	Zip Code

Home Phone	Work Phone	Date of Birth	Gender ☐ Male ☐ Female	Social Security No.	Annual Base Salary

PRE-TAX CONTRIBUTIONS Department of Treasury Federal Regulations permits health/dental contributions to be deducted from your gross pay *before taxes* resulting in less tax liability. ☐ **YES, I want this tax savings option.** ☐**NO, I DO NOT want this tax savings option.**

HEALTH PLAN –BCBSFL, Inc.

- ☐ I wish to enroll
- ☐ I wish to drop
- ☐ Add a Dependent
- ☐ Delete Dependent
- ☐ Keep current participation with no changes
- ☐ I do not wish to participate

Level of Coverage

- ☐ Employee Only
- ☐ Employee +One
- ☐ Family

DENTAL PLAN-Florida Combined Life

- ☐ I wish to enroll in:
  - ☐ **Plan A**
  - ☐ **Plan B**
- ☐ I do not wish to participate

Level of Coverage

- ☐ Employee Only
- ☐ Employee + One
- ☐ Family

NEW PLAN & PROVIDER for 2011
Current Dental coverage will not transfer

VISION PLAN-Humana Specialty Benefits

- ☐ I wish to enroll
- ☐ I wish to drop coverage
- ☐ Add a Dependent
- ☐ Delete a Dependent
- ☐ Keep current participation with no changes
- ☐ I do not wish to participate

Level of Coverage

- ☐ Employee Only
- ☐ Employee + One
- ☐ Family

√ if applicable Health	Dental	Vision	Last Name, First Name, MI	Relationship	Gender M / F	Date of Birth	Social Security #	Dependent: You Support	Lives With You	Is a Student
☐	☐	☐	Same as above	Employee						
☐	☐	☐		Spouse						
☐	☐	☐								
☐	☐	☐								
☐	☐	☐								
☐	☐	☐								
☐	☐	☐								
☐	☐	☐								

FLEXIBLE SPENDING ACCOUNT (Minimum of $100–Maximum of $10,000 annually Health Care/$5,000 Dependent Care) **Complete FSA form attached.**

☐ I elect to contribute $____________ for the plan year to a Health Care FSA on a pre-tax basis

☐ I elect to contribute $____________ for the plan year to a Dependent Care FSA on a pre-tax basis

SUPPLMEMENTAL LIFE INSURANCE Employee Basic Life coverage for 1x annual salary is provided by the City. Optional Employee Supplemental Life coverage is available in multiples of $10,000 not to exceed $250,000. Spouse life maximum coverage is one-half of employee's elected coverage not to exceed $100,000. **Complete Supplemental Life form attached.**

☐ Employee Supplemental Life $____________ ☐ Spouse $____________ ☐ Child(ren) $5,000 per child

DISABILITY INSURANCE Short-Term Disability provided by the City pays 60% of regular salary; Long-Term Disability provided by the City pays 40% of employee's regular salary. Employee may opt to buy-up coverage to meet 60% of regular salary. Coverage is subject to approval by insurance company. **Complete Long Term Disability Buy Up Form attached.**

☐ LTD Buy-Up (Cost: Annual Base Salary $_________ ÷ 12 = _________ ÷ 100 x 0.62 x 12 ÷ 26 = $_________ per pay period)

BENEFICIARY INFORMATION

EMPLOYEE'S BENEFICIARY If to be split, ______% to each	Primary (Name, Relationship, Address, if known)
	Contingent
SPOUSE'S BENEFICIARY If to be split, ______% to each	Primary (Name, Relationship, Address, if known)
	Contingent
CHILD(REN)'S BENEFICIARY If to be split, ______% to each	Primary
	Contingent

The information provided above is true and correct to the best of my knowledge. I understand & accept the provisions on the reverse side of this form.

Signature	Date Signed

For Internal Use Only – Payroll Deductions (Per Pay Period)

Medical $__________	Dental $_________	Vision $_________	Flex $__________	Supp Life $_________	LTD Buy-up $________

PROVISIONS

By signing this form, you are authorizing deductions from your earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required. Benefits for which you will be eligible are in accordance with the terms of the Certificate of Coverage.

DOCUMENTATION REQUIREMENTS FOR COVERAGE CHANGES

After initial enrollment in the plan, changes are permitted during the City's annual enrollment period. If you elect to have your premium contributions deducted on a pre-tax basis, changes at any other time may be made only for certain change of status events as shown below, and only if your request and any required supporting documentation is received in Employee Benefits no later than 31 days after the status event. If you have not elected pre-tax deductions many of the same requirements are contained in the group health and dental plan. The information on this page is a summary. Please refer to the group plan description and/or the pre-tax plan for detailed information.

Change In Legal Marital Status. Copy of marriage certificate, divorce decree or death certificate must be attached.

Change In the Number Of Dependents (including birth, adoption or placement for adoption, or death of a dependent). Copy of birth certificate, death certificate, court order of legal custody or other documentation is required.

Change In Employment Status (resulting in gain or loss of eligibility for coverage for an employee, spouse or dependent). Copy of COBRA or HIPAA notice or letter from employer must be attached stating date eligibility and/or coverage will begin/cease must be attached.

Dependent Satisfies (Or Ceases To Satisfy) Dependent Eligibility Requirements. Written documentation may be required including but not limited to certifications, court orders or other legal documents. Required documentation must be provided.

Change In Residence (Outside Of Network Area). Must result in an individual gaining or losing eligibility. Written documentation must be provided.

Other: Explain and provide supporting documentation.

DEPENDENT ELIGIBILITY An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this plan. The Covered Employee's spouse under a legally valid existing marriage; dependent child of the Employee or the Employee’s spouse, as set forth below:

The Patient Protection and Affordable Care Act (PPACA) legislation passed on March 23, 2010 and requires coverage be provided for dependent children up to at least age 26 without any qualification. Coverage will end at the end of the calendar year in which the child turns age 26. The employee will be required to submit a copy of the child’s birth certificate naming the employee or the employee’s spouse as the child’s parent or appropriate court order/adoption decree, naming the employee or the employee’s spouse as the child’s legal guardian or custodian. Dependent children who have other job-based group health coverage available to them are not eligible under the City’s health plan. The City will also continue to provide coverage for dependents age 26 to age 30 if the state mandated eligibility requirements are met.

The Employee must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.