CITY OF SOUTHFIELD
2021 PERSONAL ENROLLMENT FORM - SPDC

EMPLOYEE INFORMATION	☐ CHECK BOX IF ANY OF THE INFORMATION BELOW HAS CHANGED		
Name	Last 4 Digits of Social Security #	❑ Male ❑ Female	
Address (number & street)	City	State	ZIP Code
Date of Birth / Primary Phone ( )	Marital Status ☐ Single ☐ Married ☐ Divorced	Medicare Eligibility (provide copy of card(s)) ☐ Part A ☐ Part B ☐ Part A & B	

1. MEDICAL AND PRESCRIPTION DRUG PLAN

	Circle the option of your choice below:	BI-WEEKLY CONTRIBUTION Single	2 Person	Family	Circle your coverage level below:	MEDICAL/ RX PLAN
Select the option and coverage level of your choice. A completed Blue Cross Blue Shield or HAP application form is required if you are enrolling removing, or making any changes to your coverage.	• Community Blue PPO 10 with $5/$30/$60 Rx	$45.51	$192.84	$210.41	Single	$ _____ Bi-Weekly Contribution
	• Community Blue PPO 12 with $7/$35/$70 Rx	$0.00	$71.56	$58.80	2 Person	
	• HAP HMO with $5/$30/$45 Rx	$47.27	$173.14	$40.66	Family	
	• Waive – No Coverage	$0	$0	$0	Waive	

2. AETNA DENTAL PLAN

	Circle the option of your choice below:	BI-WEEKLY CONTRIBUTION Single	2 Person	Family	Circle your coverage level below:	AETNA DENTAL PLAN
Select the option and coverage level of your choice. A completed Aetna Enrollment/Change Form is required if you are enrolling for the first time or making any changes.	• Aetna Dental Plan	$0	$0	$0	Single	$ _____ Bi-Weekly Contribution
	• Waive - No Coverage				2 Person	
					Family	

3. BCBSM VISION PLAN

	Circle the option of your choice below:	BI-WEEKLY CONTRIBUTION Single	2 Person	Family	Circle your coverage level below:	BCBSM VISION PLAN
Select the option and coverage level of your choice. A completed BCBSM Enrollment/Change Form is required if you are enrolling for the first time or making any changes.	• BCBSM Vision Plan	$0	$0	$0	Single	$ _____ Bi-Weekly Contribution
	• Waive - No Coverage				2 Person	
					Family	

4. HEALTH CARE FSA

	Circle the option of your choice below:	HEALTH CARE FSA
Select the option of your choice. The annual IRS maximum for this benefit is $2,700.	• Health Care FSA ($103.84 bi-weekly maximum)	$ _____ Bi-Weekly Contribution
	• Waive – No Coverage	

5. DEPENDENT CARE FSA

	Circle the option of your choice below:	DEPENDENT CARE FSA
Select the option of your choice. The annual IRS maximum for this benefit is $5,000.	• Dependent Care FSA ($192.30 bi-weekly maximum)	$ _____ Bi-Weekly Contribution
	• Waive – No Coverage	

6. ADDING IT ALL UP

	TOTAL – MONTHLY CONTRIBUTION
After you have made your elections, add up your Monthly Contribution (Credit) amounts and enter the sum on the Total – Bi-Weekly Contribution line. This amount will be deducted from your paycheck on a pre-tax basis unless you mark this box for post-tax contribution. ☐	$ _____ Bi-Weekly Contribution

7. YOUR SIGNATURE

The following actions are prohibited:

- Attempting to submit a claim for benefits which includes attempting to fill a prescription for a person who is not eligible under this plan
- Attempting to file a claim for a participant for services which were not rendered or drugs or other items which were not provided
- Providing false or misleading information in connection with enrollment in the plan
- Providing any false or misleading information to the plan

I understand that if I partake in the actions listed above, such actions, or the knowledge of such actions taken by another, constitute fraud and will result in termination of all coverage under this plan in accordance with applicable law and insurance company policy/procedure.

I understand that I cannot change these benefit elections unless I notify HR after I experience a qualifying change in status (such as marriage, divorce, death of a spouse or a child, birth or adoption of a child, termination of employment) and the insurance carrier approves such a change. I authorize salary reduction in the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage. This agreement is subject to the terms of the City's contribution plan as amended from time to time and shall be governed by and construed in accordance with applicable laws. This benefit election form and salary reduction agreement revokes any prior benefit election and salary reduction agreement relating to such plan. My signature below acknowledges my elections for this plan year expiring December 31, 2021.

Any qualifying change in status must be reported to the City within 30 days of the qualifying event. Should I fail to inform my employer within this IRS required timeframe, I understand that I will be required to wait until the next Open Enrollment. I further agree that any paperwork required to support a change in status will be supplied to the City at the earliest point in time that it becomes available.

Date: _____ Signature: _____

Notice: This Personal Enrollment Form is your formal offer of medical coverage as required by the Patient Protection and Affordability Act (PPACA). Further information regarding an offer of coverage or the requirements of PPACA can be obtained from the City of Southfield or through www.healthcare.gov.

BENEFIT WAIVER FORM

Employee Name _____
(Last Name, First Name, Initial)

Dept: _____ Job Title: _____

In place of coverage under the Health Insurance Plan of the City of Southfield, the employee elects the Health Insurance waiver allowance. The cash payments made in lieu of benefits are considered taxable income by the IRS.

Effective 2021 plan year, I am waiving the following benefit options available to me through the City of Southfield:

- ☐ Medical
- ☐ Dental
- ☐ Vision

The employee certifies that he/she and all members of the employee's tax family (if applicable) has minimum essential group health coverage and are not receiving and will not receive individual coverage from any source. The employee waives the City of Southfield provided health insurance coverage for themselves and all member of the employee's tax family (if applicable).

An Employee shall not be eligible for the Conditional Waiver Program, if the Employee, or any member of Employee's Tax Family (Tax Family means the Employee and all other persons whom Employee claims a personal exemption on his or her federal income tax return) purchases individual coverage, whether or not purchased on the Marketplace/Exchange during the plan year. To be eligible for the Conditional Waiver Program, the Employee and all members of the Employee's Tax Family must receive minimum essential group health plan coverage during the plan year.

By signing this attestation, I understand I can rejoin the benefit options that I am waiving during the 2021 Plan Year only if I lose coverage due to a Qualifying Event. I may re-enroll in the City of Southfield plan upon timely notification, generally within thirty (30) days of my loss of coverage. Absent of a Qualifying Event, I understand I cannot enroll in this plan until the next annual open enrollment period.

Employee Signature _____ Date _____