CITY OF NAPOLEON

2016 BORMA -Medical Coverage

☐ New Hire	☐ Open Enrollment	☐ Change due to qualifying event

Employee Information (please print clearly)

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

Dependent Information (if to be enrolled)

Name (Last, First, Middle Initial)	SSN (Required for Spouse)	Date of Birth	Gender
Spouse			
Child			
Child			
Child			

Member Election Information

	Aetna Conventional PPO Medical Plan Bi-weekly	Aetna High Deductible Plan / H.S.A Bi-weekly
Single	☐ $ 32.82	☐ $ 28.59
Employee + Spouse	☐ $ 65.64	☐ $ 57.17
Employee + Child(ren)	☐ $ 59.08	☐ $ 51.45
Family	☐ $ 98.46	☐ $ 85.76
Waiver of Coverage	☐ Waiving Medical Coverage	

ELECTION & DEDUCTION AUTHORIZATION

I understand that by signing this form, I am making a binding election for my benefits for the period January 1, 2016 through December 31, 2016. 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*.

I verify that all the information I provided on this enrollment form is true and correct to the best of my knowledge.

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 1/1/2016, 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.

Life Insurance Beneficiary Designation Form

Full Name of Beneficiary(ies):	Address:
Relationship:	
Contingent Beneficiary:	Address:
Relationship:	
Signature of Employee:	Date:

The City of Napoleon provides employees with basic Life & AD&D Insurance. Please update your Life Insurance Beneficiaries.

INSTRUCTIONS FOR NAMING BENEFICIARY

1. Give complete name of beneficiary and relationship to you (indicate "non-relative" and present address).
2. If beneficiary is a married woman, show given name (Mary J. Doe not Mrs. John Doe).
3. Unless otherwise provided, proceeds will be paid in equal shares to those primary beneficiaries who survive you, but if no primary beneficiaries survive you, such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive you.

NOTE: You may change your beneficiary at any time in accordance with the conditions and provisions of the group policies.