City of St. Augustine Enrollment & Change Form

Employee Information

Name: _____ SSN: _____ Birth Date: _____

Address: _____ Zip Code: _____ Gender: _____

City: _____ Marital Status: _____

Reason for change: _____ Hire Date: _____

Type of Change: _____ Effective Date: _____

Benefit Election

COVERAGE TYPE	Medical	Dental	Optional Life
Employee Only			
Employee & Child(ren)			
Employee & Spouse			
Family			

Dependent Information

Name (First, Middle, & Last if different)	Relationship	SSN	Birth Date	Gender

VOLUNTARY OPTIONAL LIFE INSURANCE

COVERAGE TYPE	Elect	Waive	Amount Requested
Employee 1x - 5x salary to Max GI $120,000*			
Spouse - Max $25,000*			
Child(ren) -			$10k from 14 days old to age 25

If you waive coverage during your initial enrollment, you will be required to complete an Evidence of Insurability (EOI) form and coverage is not guaranteed.

*You must complete an EOI form if electing Voluntary Life coverage amounts in excess than the Guarantee Issue (GI) amount listed above. If you have elected an amount that requires completion of the EOI form, please see Human Resources. Deductions for elections over the Guarantee Issue amount are not taken until the EOI is reviewed and approved by Carrier.

EMPLOYER PAID LIFE INSURANCE - Below Class to be Completed by Human Resources

Class 1 - $50k Life Class 2 - $10k Life + 1x Salary Life

Primary Beneficiaries

Name	Relationship	%	Address & Phone	SSN

Contingent Beneficiaries

Name	Relationship	%	Address & Phone	SSN

Premium Only IRS Code Section 125

I understand that if my required premium contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

I understand that:

I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have changes in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I take an unpaid leave of absence, a substantial change in family's health coverage due to change in my spouse's employer sponsored health coverage, etc.). Noticfication of change must be within 30 days of the qualifying event.

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.

I hereby authorize my employer to reduce my cash compensation by the amount(s) indicated for each pay period during the plan year following the date on which this agreement is signed.

I understand that my election may impact my future Social Security benefits.

I have read and understand this agreement and to the best of my knowledge it is true, correct and complete. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee Signature _____ Date _____

Employer Signature _____ Date _____