Newport News
Where Great Things Are Happening

BENEFIT ENROLLMENT/CHANGE FORM

FOR HR USE ONLY:

Effective Date: _____

☐ New Hire ☐ Change

Employee Information

Last Name	First Name	MI	SSN	DOB

Address	City	State	Zip Code	Employee ID#

Home Phone	Cell Phone	Email Address

Coverage Elections

Medical: ☐ POS ☐ Equity HDHP (POS) ☐ Decline Coverage

Coverage Level: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Family

Dental: ☐ Delta PPO Plus Premier ☐ Decline Coverage

Coverage Level: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Family

Vision: ☐ Vision Service Plan ☐ Decline Coverage

Coverage Level: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Family

Special Enrollment Notice and Certification *(Please review and initial below if you waive medical, dental and/or vision coverage)*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I understand that I am declining enrollment for myself and/or my eligible dependents (including my spouse) as indicated above because of other medical/dental/vision insurance or other group medical/dental/vision plan coverage. I may be able to enroll myself and/or my eligible dependents in this plan if I/my eligible dependents lose eligibility for that other coverage (or if the employer stops contributing towards my/my eligible dependentsô other coverage). I understand that I must request enrollment no more than 31 days after the date the other medical/dental/vision plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employerôs next annual open enrollment period. I understand that in order to request special enrollment or obtain more information, I should contact the Department of Human Resources Benefits Division.

Initial here _____

Health Saving Account: $_____ per pay period ☐ Decline Coverage

Only available if elected Equity HDHP (POS)

Cigna Short Term Disability: ☐ Enroll ☐ Decline Coverage

Cigna Long Term (10% Buy-up) ☐ Enroll ☐ Decline Coverage

Dependent Information (Additional)

Name (Last, First MI)	Birthdate	Relation	SSN	Gender	Medical	Dental	Vision	Add/Drop

☐ Check if Additional Dependents (Include Additional Dependent Form)

PLEASE PROVIDE VERIFICATION DOCUMENTATION FOR ALL COVERED DEPENDENTS

I understand that selections cannot be changed during the plan year (Jan. 1 – Dec. 31) unless I experience a qualifying event (birth/adoption of a child, divorce, death, spouse's loss of employment, marriage, dependent loses eligibility, etc.). I further understand that Human Resources Benefits Division must be notified within 31 days of the qualifying event (i.e. family status change) in order for there to be a change in enrollment. Medical, dental and vision benefits are deducted on a pre-tax basis.

_____ _____

Employee Signature Date

FOR HR USE ONLY: Initials/Date

Dental, vision and/or medical updated: _____ /_____

MUNIS updated: _____ /_____

FSA updated: _____ /_____

VRS Plan: _____ RHS# _____

VRS Member# _____