***** Open Enrollment ends June 18, 2021 at 5 pm *****

Effective date: 07/01/2021

CITY OF TURLOCK
OPEN ENROLLMENT EMPLOYEE ELECTION FORM
July 1, 2021 through June 30, 2022

If choosing medical, select either the Traditional PPO & HDHP w/HSA:

Enrollment Choices	☐	Medical, Dental, & Vision Coverage	☐	Traditional PPO	☐	High Deductible Health Plan w/HSA	☐	Life/LTD ONLY	☐	Other – please specify below
	☐	Vision only (also includes life/LTD)		**DEFFERED COMP SELECTION**	☐	Deferred Comp in lieu Medical and Dental; enroll Vision only	☐	Deferred Comp in lieu of ALL benefits; waives all coverage		

Social Security Number: _____-_____-_____ Date of Hire: _____ / _____ / _____

Employee's Last Name: _____ First Name: _____ MI: _____

Employee's Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

GENDER: ☐ Male ☐ Female HDHP Only – Driver's License #: _____

Job Title: _____ Union Affiliation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Registered Domestic Partner (DP)

Marriage: date married _____ / _____ / _____ Registered DP: date registered with SoS: _____/_____/_____

List your dependents to be covered under this group plan (use a separate page for additional dependents, if necessary):

Name of Dependent	Relationship	Social Security #	Date of Birth	Address (if different)

Are you or any dependent currently eligible for Medicare? Yes ___ No____

If yes, which individual(s): _____ Effective date: _____

Are you or any dependent(s) currently enrolled in Medi-Cal/Medicaid? Yes ____ No ____

If yes, which individual(s): _____ Effective date: _____

Does anyone covered by the City of Turlock plan intend to continue any other medical coverage *in addition* to this coverage?

Yes____ No____ If yes, what type of coverage (circle one)? Other group plan Individual plan TriCare/VA Medicare Other

Name of Carrier: _____ Policy Number: _____

Which family members are covered by this other insurance plan? _____

I certify that the information that I have provided on this form is true and correct to the best of my knowledge. I hereby authorize deduction from my compensation for any contributions that are required by me, if any. I also understand that outside of open enrollment, unless there is a qualified life event reported to Human Resources within 30 days from the event, that I cannot make changes to my plan until the next open enrollment period.

Signature: _____ Date: _____

*****Important Note: In addition to this form, everyone must complete the online open enrollment process by logging on to the HR ESuite portal. The link to the HR portal is https://hrportal.turlock.ca.us/Websites.HR.Portal**

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Spending Accounts: Medical Flexible Spending Accounts, Dependent Daycare, and Health Savings Account Elections
Employee voluntary contributions: I request the following amounts to be voluntarily deducted pre-tax per pay period[1] for each pay period beginning July 1, 2021 continuing through June 30, 2022.

Specific to medical flexible spending accounts and dependent daycare: I understand that this salary reduction agreement cannot be revoked or changed during the Plan period, *unless* there is a change in family status according to Federal IRS statute (i.e., marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse). The change in family status must justify the revocation or change and the IRS allows the change to be made. I understand that salary reductions must be used to reimburse qualified expenses incurred during the plan period and may not be carried over into future plan periods. If, at the end of the plan year, your total salary reduction exceeds your substantiated expenses, the difference in amounts will be the property of the employer.

Dependent Care Expenses	**Unreimbursed Medical Expenses**	**Health Savings Account [2]**
Available for all benefit eligible employees	Available for non-HDHP enrollees	Available for HDHP enrollees only
Maximum $10,500	**Maximum $2,750**	**$2,300 single, $5,000 family** **$1,000 catch-up for 55 or older**
$ _____ per pay period	$ _____ per pay period	$ _____ per pay period
$ _____ total for year (period amount x 24 pay periods)	$ _____ total for year (period amount x 24 pay periods)	$ _____ total for year (period amount x 24 pay periods)

I have examined this agreement and to the best of my knowledge, it is true, correct, and complete. I hereby authorize deduction from my compensation for any contributions that are required by me, if any. I also understand that outside of open enrollment, unless there is a qualified life event reported to Human Resources within 30 days from the event, that I cannot make changes to my plan until the next open enrollment period.

Signature: _____ **Date:** _____

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