SEATTLE HOUSING AUTHORITY

2017 BENEFITS ELECTION FORM

Please Print Clearly

Last Name (Please Print) First Name | Employee Number | Gender

Home Address - Street | City | State | Zip

Hire Date | Birth Date (M/D/Y) | Social Security Number

❑ New Hire ❑ Open enrollment ❑ Decline coverage Effective Date of Coverage_____

Reason for re-enrolling: ❑ Loss of other coverage (Attach proof of other coverage) ❑ Birth/Adoption of child
❑ Marriage/new domestic partnership (Attach affidavit of marriage/domestic partnership)
❑ Other _____

Medical Plan Selection

(Please choose ONE Medical Plan below).

Employee Premium Share

City of Seattle Preventive Plan (administered by Aetna – Group #:100290-20-012-112)
❑ Employee Only (with or without Children) $48.12
❑ Employee & Spouse/Domestic Partner (with or without Children) $98.50

City of Seattle Traditional Plan (administered by Aetna – Group #:100290-10-012-012)
❑ Employee Only (with or without Children) ..... $ - 0 -
❑ Employee & Spouse/Domestic Partner (with or without Children) $32.34

Kaiser Permanente Standard Plan (Group #: 284958)
❑ Employee Only (with or without Children) $48.40
❑ Employee & Spouse/Domestic Partner (with or without Children) $99.90

Kaiser Permanente Deductible Plan (Group #:0961055)
❑ Employee Only (with or without Children) $25.00
❑ Employee & Spouse/Domestic Partner (with or without Children) $56.92

Vision Plan
❑ Vision Service Plan .....$ - 0 –
❑ Vision Service Plan (buy-up plan).....$13.22

Dental Plan Selection *(Please choose only ONE Dental Plan)*
❑ Delta Dental of Washington ***OR*** ❑ Dental Health Services ..... None

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Add Dependent Coverage Information: List all eligible dependents to be included. Attach a list for any additional dependents. If you enroll a dependent, Aon Hewitt, the City's business partner, will send a letter to your home requesting documents that confirm the eligibility of your dependent. .

PRINTED NAME	SOC. SEC. NO.	BIRTH DATE (M/D/Y)	ENROLL IN Medical	ENROLL IN Dental/Vision
			❑ Yes ❑ No	❑ Yes ❑ No

❑ Spouse ❑ Male ❑ Female
❑ Domestic Partner ❒ Partner is claimed as my IRS tax dependent.
❑ Partner is **not** claimed as my IRS tax dependent.

			❑ Yes ❑ No	❑ Yes ❑ No

Dependent Child #1 ❑ Male ❑ Female
❑ Son ❑ Daughter ❒ Other (Step-child or Legal Guardianship)
❑ Partner's son ❑ Partner's daughter
❑ Partner's child is **not** claimed as my IRS tax dependent ❒ Partner's child is claimed as my IRS tax dependent

Incapacitated or Disabled? ❑ Yes ❑ No

NOTE: Your medical, dental and vision enrollment/changes are not valid unless this form is signed and dated on the next page.

Last Name (Please Print) First Name Social Security Number Birth Date

PRINTED NAME	SOC. SEC. NO.	BIRTH DATE (M/D/Y)	ENROLL IN Medical	Dental/Vision
Dependent Child #2 ❑ Male ❑ Female			❑ Yes ❑ No	❑ Yes ❑ No
❑ Son ❑ Daughter ❑ Other (Step-child or Legal Guardianship)				
❑ Partner's son ❑ Partner's daughter				
❑ Partner's child is **not** claimed as my IRS tax dependent ❑ Partner's child is claimed as my IRS tax dependent				
Incapacitated or Disabled? ❑ Yes ❑ No				
Dependent Child #3 ❑ Male ❑ Female			❑ Yes ❑ No	❑ Yes ❑ No
❑ Son ❑ Daughter ❑ Other (Step-child or Legal Guardianship)				
❑ Partner's son ❑ Partner's daughter				
❑ Partner's child is **not** claimed as my IRS tax dependent ❑ Partner's child is claimed as my IRS tax dependent				
Incapacitated or Disabled? ❑ Yes ❑ No				

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Coverage Options:

❑ I ACCEPT COVERAGE

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize SHA to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under the City of Seattle/SHA's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines.

Employee's signature **Date**

❑ I DECLINE COVERAGE

I decline medical coverage for myself and family members. I understand that by declining City of Seattle medical insurance, my medical coverage through the City will end, but my vision and dental insurance will continue.

I understand that if I have medical coverage elsewhere and lose the other coverage, I may enroll within 31 days of the loss of the other coverage upon providing proof of continuous medical coverage. If I have a qualifying change in family status, I may enroll within 31 days (or 60 days for a new child) of that change. If I leave Seattle Housing Authority (SHA) employment or go on a leave of absence, I will not be eligible to obtain medical coverage under the federal COBRA law through the City. However, if I retire I will be eligible to enroll in a City retiree medical plan.

If I decline coverage and have no medical insurance elsewhere, I will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless I have a qualifying change in family status. If I leave SHA employment or go on a leave of absence, I will not be eligible to obtain medical coverage under the federal COBRA law or enroll in a City retiree medical plan.

Employee's signature **Date**

Last Name (Please Print) First Name | Social Security Number | Birth Date

ACCIDENTAL DEATH & DISMEMBERMENT

Effective date _____ of coverage/change for: ❑ New Employee ❑ Canceling coverage
❑ Changing principal sum ❑ Changing type of coverage (individual or family) ❑ Changing beneficiary

❑ **YES,** I am applying for accidental death and dismemberment insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

❑ Individual ❑ Family Principal Sum $_____

BENEFICIARY: Specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, please use a separate list, sign, date, and attach to form.

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

Last Name First Name | Address | _____% of Benefit ❑ Check if Contingent

❑ **NO,** I do not wish to purchase accidental death and dismemberment coverage at this time. I understand that if I later want coverage, I may only enroll during an open enrollment time period.

SUPPLEMENTAL LONG TERM DISABILITY

Effective date _____ of coverage/change for:
❑ New employee ❑ Adding supplemental coverage ❑ Canceling supplemental coverage

❑ **YES,** I am applying for Supplemental Long Term Disability insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. I understand that my coverage will be subject to any applicable pre-existing condition exclusions. This coverage is in addition to the Basic LTD coverage provided by the City.

❑ **NO**, I do not care to participate in the City of Seattle's Supplemental Long Term Disability insurance plan. I understand that if I enroll later during an open enrollment period, my insurance will be subject to a longer pre-existing condition exclusion. I also understand that Basic LTD will still be provided by the City even if I do not elect Supplemental LTD coverage.

GROUP LONG TERM CARE INSURANCE

Effective date _____ of coverage/change for:
❑ New employee ❑ Adding supplemental coverage ❑ Canceling supplemental coverage

❑ **YES,** I am applying for Group Long Term Care insurance for:

❑ **Myself** (coverage guaranteed within specified limits for new employees)
❑ **and Spouse/Domestic partner** (coverage not guaranteed)
(NOTE: A separate enrollment form from UNUM must be attached to this Benefits Enrollment form)

❑ **NO**, I do not wish to apply for Group Long Term Care insurance for myself or my spouse/domestic partner. I understand that if I/we want to apply for this Long Term Care (LTC) coverage in the future, I/we will be required to complete a LTC application, and that the coverage will not be guaranteed.

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By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carriers to obtain, examine or release information needed to process claims for myself or my family.

►Employee Signature _____ Date_____

Last Name (Please Print) First Name Social Security Number Birth Date

BASIC GROUP TERM LIFE INSURANCE

Effective date _____ of coverage/change for: ❑ New Employee ❑ Adding coverage ❑ Canceling coverage

❑ **YES**, I am applying for group term life insurance according to the terms of the group policy issued to the City of Seattle, with coverage equaling 1½ times my annual salary. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

❑ **NO,** I do not care to participate in the City of Seattle's group term life insurance plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

BASIC GROUP TERM LIFE INSURANCE – Limited Coverage

Effective date _____ of coverage/change for: ❑ New Employee ❑ Adding coverage ❑ Canceling coverage

❑ My gross salary is greater than $33,000, and I am applying for Basic GTL coverage limited to $50,000 (instead of the above Basic GTL coverage equal to 1½ times my salary) according to the terms of the group policy issued to the City of Seattle. I authorize premiums to be deducted from my salary. Previously submitted enrollment information for Basic GTL insurance, excluding current beneficiary information, is superseded by this election. I understand if I later want to increase my GTL coverage amount, I will be required to provide a Medical History Statement. My signed and notarized *Waiver Agreement* accompanies this application.

SUPPLEMENTAL GROUP TERM LIFE INSURANCE -- INDIVIDUAL COVERAGE

Effective date _____ of coverage/change for: ❑ New employee ❑ Adding coverage ❑ Canceling coverage ❑ Changing coverage amount

❑ **YES**, I am applying for Supplemental GTL Insurance for myself in the following amount according to the terms of the group policy issued to the City of Seattle. The coverage amount selected below does not exceed four times my annual salary rounded to the next lower multiple of $5,000 if not already a multiple of $5,000. ***I understand this coverage can only be purchased if I have also elected Basic GTL or Basic GTL - Limited Coverage***. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

Coverage Amount: $_____ Current Annual Salary: $_____

❑ **NO**, I do not care to participate in the City of Seattle's Supplemental GTL plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

SPOUSE OR DOMESTIC PARTNER COVERAGE

Effective date _____ of coverage/change for: ❑ New employee ❑ Adding coverage ❑ Canceling coverage ❑ Changing coverage amount

❑ **YES**, I am applying for Supplemental GTL Insurance for my spouse/domestic partner in the amount of **$_____** according to the terms of the group policy issued to the City of Seattle. **This coverage amount is at least $5,000 or a multiple of $5,000, and is *not greater* than 50% of my Individual Supplemental GTL coverage amount.** I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, and benefits for any loss are payable to me. I authorize deductions from my salary for contributions I am required to make toward the cost of this insurance.

❑ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for a spouse or partner. I understand that if I currently have a spouse or partner, s/he will be required to submit a Medical History Statement if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

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By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

►Employee Signature _____ Date_____

Last Name (Please Print) First Name | Social Security Number | Birth Date

DEPENDENT CHILD COVERAGE

Effective date _____ of coverage/change for: ❑ New employee ❑ Adding coverage ❑ Canceling coverage ❑ Changing coverage amount

❑ **YES**, I am applying for Supplemental GTL Insurance for my child(ren) or my spouse's/domestic partner's child(ren) in the amount selected below according to the terms of the group policy issued to the City of Seattle. I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, covered child(ren) must meet the eligibility criteria, and benefits for any loss are payable to me. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (One amount covers all children)

❑ **$2,000** ($.36 per month) ❑ **$5,000 ($.90 per month)** ❑ **$10,000 ($1.80 per month)**

❑ **NO,** I do not care to select the City of Seattle's Supplemental GTL insurance plan for dependent children. I understand that if I currently have a dependent child(ren), I may apply for coverage later only during an annual open enrollment period.

BENEFICIARY INFORMATION

Effective date of beneficiary change _____

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, use a separate list, sign, date and attach to this form.

Beneficiaries for Basic Group Term Life

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

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Beneficiaries for Supplemental Group Term Life

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

Last Name (Please Print) First Name | Address | _____% of Benefit ❑ Check if Contingent

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By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

►**Employee Signature** _____ **Date** _____