SEATTLE HOUSING AUTHORITY
2023 BENEFITS ENROLLMENT FORM

Please Print Clearly

Last Name **First Name** **Employee Number** **Hire Date** **Gender** **Birth Date**

Home Address (Street, City, State, Zip) **Social Security Number**

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.

☐ 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 #:100290-30-021-112)
☐ 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 #:0100290-30-001-012)
☐ Employee Only (with or without Children) ..... $ - 0 -
☐ Employee & Spouse/Domestic Partner (with or without Children).....$32.34

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

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

Vision Plan *(Please choose only ONE Vision Plan)*
☐ Vision Service Plan (Group #: 12080805-1048) .....$ - 0 –
☐ Vision Service Plan (buy-up plan) (Group # 12080805-1103).....$10.38

Dental Plan Selection *(Please choose only ONE Dental Plan)*
☐ Delta Dental of Washington (Group #160) ***OR*** ☐Dental Health Services (Group #W203)…$ - 0 –

Limited Health Care Service Contractor 100 W. Harrison St, Suite S-440, S. Tower, Seattle, WA 98119

Dependent Enrollment: List all eligible dependents to be enrolled. Attach a list for any additional dependents.

PRINTED NAME	SOC. SEC. NO.	BIRTH DATE (M/D/Y)	ENROLL IN Medical	Dental/Vision
_____ ☐Spouse ☐ Male ☐ Female	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
☐ Domestic Partner - ☐ Partner is claimed **OR** ☐ Partner is **not** claimed as my IRS tax dependent.				
_____ **Dependent Child #1** ☐ 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 **OR** ☐Partner's child is claimed as my IRS tax dependent: Incapacitated or Disabled? ☐ Yes ☐ No				
_____ **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 **OR** ☐Partner's child is claimed as my IRS tax dependent Incapacitated or Disabled? ☐ Yes ☐ No				

If you enroll a dependent, Alight Solutions will mail a letter requesting documents to confirm your dependents eligibility.

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 enrollment 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 30 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 30 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**

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.

☐ **Employee Only** ☐ **Employee & Family** **Principal Sum $**_____

BENEFICIARY: Specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. 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. Please Print:

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

☐ **NO,** I do not wish to purchase accidental death and dismemberment coverage at this time.

SUPPLEMENTAL LONG TERM DISABILITY

Effective date_____of coverage/change for: ❑New employee ❑Adding coverage ❑Canceling 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 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 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 coverage ❑Canceling coverage

☐ **YES,** I am applying for Group Long Term Care insurance for**: You will be subject to the WA Cares payroll tax even if you enroll in the Unum LTC benefit

☐ **Myself** (coverage guaranteed within specified limits for new employees)
☐ **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.

BASIC GROUP TERM LIFE INSURANCE (Life)

Effective date_____of coverage/change for: ☐ New Employee ☐ Adding coverage ☐ Canceling coverage

☐ **YES**, My gross salary is greater than $33,000, and I am applying for Basic GTL coverage limited to $50,000 (instead of the Basic GTL coverage equal to 1½ times my salary) according to the terms of the group policy issued to the City of Seattle.

OR:

☐ **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, maximum of $2,500,000 (basic and supplemental combined). A medical history may be required to enroll or to increase coverage.

OR:

☐ **NO,** I do not care to participate in the City of Seattle's group term life insurance plan.

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 or $2,500,000 when combined with basic life, whichever is less. A medical history may be required to enroll or to increase coverage.

Coverage Amount: $_____Current Annual Salary: $_____

☐ **NO**, I do not care to participate in the City of Seattle's Supplemental GTL plan.

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, maximum of $500,000 or 100% of the my combined basic and supplemental amount, whichever is less.** A medical history may be required to enroll or to increase coverage. I understand benefits for any loss are payable to me.

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for a spouse or partner.

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 covered child(ren) must meet the eligibility criteria and benefits for any loss are payable to me. (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.

BENEFICIARY INFORMATION

Effective date of beneficiary change _____

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. Please specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. 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 First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

Beneficiaries for Supplemental Group Term Life

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

_____

Last Name First Name Address Date of Birth Relationship % Benefit – Check if Contingent ☐

I understand that by waiving individual optional benefit coverages for myself and dependents, the following may apply: Initial enrollment may only happen during an open enrollment period. Changes to coverage amounts are subject to carrier approval. A Medical History Statement may be required and coverage may be provided at the discretion of the insurance company. I and my dependents may be subject to a longer pre-existing condition exclusion. ** Employee Initials

By signing below, I declare that the all the information on each page of this form (pages 1-4) is true, correct and complete to the best of my knowledge, that I have read and understand the enrollment 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. I authorize deductions from my salary, including PFML benefits, for contributions I am required to make toward the cost of each elected insurance.

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