City of Tyler Enrollment/Change/Termination Form

☐ **Open Enrollment** ☐ **New Hire** ☐ **Change of Family Status** ☐ **Change of Coverage / COBRA Election**

PERSONAL INFORMATION					
Last Name:	First Name:	MI:	Social Security #:		
Address:		City:	State:	Zip:	
Date of Birth:	☐ Male ☐ Female	Phone:	E-Mail:		
Marital Status:	○ Single	○ Married	○ Divorced	○ Surviving Spouse	

EMPLOYMENT INFORMATION		
Employment Date:	Dept #/Division:	Effective Date:

BENEFIT ELECTIONS - MEDICAL ☐ **DECLINE COVERAGE**				
(Please mark appropriate box by each line item of coverage)	**Employee Only**	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
○ **Rose Plan**	☐	☐	☐	☐
○ **Azalea Plan**	☐	☐	☐	☐

BENEFIT ELECTION – DENTAL ☐ **DECLINE COVERAGE**				
(Please mark appropriate box by each line item of coverage)	**Employee Only**	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
○ **Delta Dental PPO Plan**	☐	☐	☐	☐

BENEFIT ELECTION – VISION ☐ **DECLINE COVERAGE**				
(Please mark appropriate box by each line item of coverage)	**Employee Only**	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
○ **Vision Gold $100 Base Plan 1**	☐	☐	☐	☐
○ **Vision Gold $150 Buy Up Plan 2**	☐	☐	☐	☐

BENEFIT ELECTION – SHORT TERM DISABILITY

☐ ENROLL ☐ OPT OUT

BENEFIT ELECTION – FLEXIBLE SPENDING ACCOUNTS

☐ Health FSA	Election Amount: $ *Maximum Contribution: $2,750*	☐ Dependent Care FSA	Election Amount: $ *Maximum Contribution: $5,000*

DEPENDENT INFORMATION – PLEASE COMPLETE

Last, First Name	Relationship	SSN	DOB	Gender	Coverage Requested			Type of Change
					☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Delete
					☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Delete
					☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Delete
					☐ Medical	☐ Dental	☐ Vision	☐ Add ☐ Delete

✓ If adding a spouse you must attach a copy of your marriage certificate

✓ If adding dependent children you must attach a Verification of Dependent Eligibility form for each child with all required documentation.

COORDINATION OF BENEFITS – MEDICAL PLAN ONLY

Are you or your dependents, covered under any ***other*** Group (Employer Sponsored) Medical Plan?	☐ Yes ☐ No
Is there a Qualified Medical Child Support Order to provide Insurance for dependent child(ren)?	☐ Yes ☐ No
If so, who is responsible for covering dependent children?	Name:

☐ **I elect to have all eligible Payroll Premiums deducted from my pay before taxes**

☐ **I decline to participate in any of the accounts where I can save tax dollars**

I hereby authorize the City of Tyler to make periodic salary deductions from my paycheck to pay for the benefits I have elected. Furthermore, I understand my options under the Employee Benefit Plan. My election remains enforce until either I change it, at an Annual Open Enrollment, or I experience a qualifying event. My signature below indicates my agreement and the agreement of my dependents that the information entered on this enrollment form is true and correct.

★ Employee Signature _____ Date: _____

Employer Signature _____ Date: _____