CITY OF FORT LAUDERDALE | EMPLOYEE BENEFITS

2020 OPEN ENROLLMENT

October 24 - November 8, 2019

MGMT/SUPV/PROF OPEN ENROLLMENT FORM

Includes TAX-QUALIFIED Dependents

NO ACTION REQUIRED TO KEEP CURRENT BENEFITS

(EXCEPT for Flexible Spending Accounts (FSAs) – You Must Re-Enroll in FSAs for 2020)

Instructions: Automatic rollover - 2019 Benefits will automatically continue (EXCEPT for Flexible Spending Accounts (FSAs)), effective January 1, 2020, unless you cancel or make a change. If you wish to continue funding a FSA(s), you MUST re-enroll in a FSA(s) for 2020. Follow 3-simple steps below:

Step 1: Review your current 2019 Benefits Statement, 2020 Open Enrollment Newsletter and Benefits Information on LauderShare or at www.fortlauderdale.gov/benefits. If you do not want to make any changes AND you do not want a FSA(s), **STOP HERE** (no further action required). If you want to make ANY changes or enroll in a FSA(s) for 2020, continue to Step 2.

Step 2: Enroll/Make Changes - There are 2 options:

Option 1. Self-Enroll by Completing and Submitting this Form:

- If you are not currently enrolled and wish to enroll or make **ANY** changes to your **Medical, Dental, Vision, Flexible Spending Accounts, Voluntary Group Term Life Insurance or Legal Insurance,** please complete only the sections of this form that you wish to change. This includes adding or deleting a dependent.
- To carryover all 2019 enrollments with no changes, except 2020 FSA enrollment, complete sections 1 and 9; sign section 11 and submit the form.

Option 2. Meet with a Professional Benefits Counselor/Enroller:

- For assistance with completing and submitting this form and benefits information.
- To enroll in or make changes to any of the Aflac Voluntary Benefits you must schedule an appointment to meet with a Professional Benefits Counselor/Enroller at http://www.myenrollmentschedule.com/lauderdale or by calling 1-866-998-2915.

Step 3: Sign, Submit Form and Documents:

- **Completed enrollment form and required documents must be received by Benefits Section, HR no later than November 8, 2019.**
- Please keep a copy of this completed form for your records.
- Verify the deductions on your January 3, 2020 paycheck and report any discrepancies no later than January 10, 2020.

Four (4) Ways to Submit this Completed Form (and any required documents) (DO NOT EMAIL):

1. Meet with a Professional Benefits Counselor/Enroller. (Retain a copy, stamped by the Enroller, as proof of receipt)
2. Fax to Benefits-HR: 954-828-5328 (Retain a copy of the fax confirmation)
3. Drop Off in Person to Benefits Section, HR at City Hall, 3rd Floor. (Retain a copy, stamped by HR, as proof of receipt)
4. Mail to: City of Fort Lauderdale (Retain proof of mailing)
   Attn: Benefits Section, HR
   100 N Andrews Ave 3rd Floor
   Fort Lauderdale, FL 33301

PLEASE DO NOT EMAIL THIS COMPLETED FORM DUE TO CONFIDENTIALITY.

Start Enrollment/Changes:

1. Employee Data (please print):				
LAST NAME		FIRST NAME		MI
DATE OF BIRTH (MM/DD/YYYY)	CELL PHONE	WORK PHONE	GENDER: MALE ☐ FEMALE ☐	
EMPLOYEE ID NUMBER	EMAIL			

Approved by: Tarlesha W. Smith, Esq., Director of Human Resources
Uncontrolled in hard copy unless otherwise marked
Rev: 1 | Date: 10/01/2019 | Print Date: 10/07/2019

WE BUILD COMMUNITY

2. ☐ *Opt-Out/Decline ALL City Benefits Coverage (Medical, Dental, Vision, Flexible Spending Accounts, Voluntary Group Term Life Insurance and Legal Insurance) for 2020 (excludes City Paid Life Insurance and Voluntary Aflac benefits). Please proceed to page 3 to complete your beneficiary designation in section 8. Sign and date section 11 on page 4.

ALL RATES ARE BIWEEKLY

Select your plan(s) and enrollment level(s) for 2020.

3. Cigna MEDICAL Plans (Pre-tax):

☐ ***Opt-Out/Decline medical coverage for 2020** (Refer to Page 4)

MGMT/SUPV/PROF	Open Access Plus In-Network 1 (OAPIN 1) or HMO 1	Open Access Plus In-Network 2 (OAPIN 2) or HMO 2	Consumer Driven Health Plan (CDHP) – With Health Reimbursement Account (HRA)
Tier of Coverage	Total	Total	Total
Employee (EE) Only	☐ $104.46	☐ $79.31	☐ $42.71
Employee + Spouse/DP	☐ $213.89	☐ $161.06	☐ $87.85
Employee + Child	☐ $141.77	☐ $106.15	☐ $58.57
Employee + Children	☐ $192.76	☐ $145.20	☐ $79.31
EE + Family (Spouse/DP+Child(ren))	☐ $297.22	☐ $223.29	☐ $122.01

Please identify whether you have a ☐ **Non-Tax Qualified DOMESTIC PARTNER** or ☐ **ADULT CHILD** (after end of calendar year in which they turn Age 26 – age 30) and contact Benefits/HR for a separate Enrollment Form.

A: TOBACCO AFFIDAVIT (NOTE: This Tobacco affidavit only applies to employees enrolling in or making changes to their medical plan.)

Do you use Tobacco (currently smoke any form of tobacco or apply tobacco to the gums regardless of the method or frequency of use)? ☐ **Yes** ☐ **No**

By signing section 11 on page 4 of this form, I hereby certify that my selection above is complete and true.

- I understand that tobacco includes any form of tobacco products that are smoked (e.g. cigarettes, cigars, pipes, vaping, electronic cigarettes), applied to the gums (e.g., dipping, chewing tobacco or snuff), and/or inhaled.
- I understand that if I currently use or begin to use tobacco products, I am subject to the $25/ pay period surcharge. Please see the Benefits Handbook for additional information.
- I understand that I must report any change in my tobacco use to the Benefits Section, Human Resources Department.
- I understand that if I (a participant in the City's Medical Plan) use tobacco products and do not notify the City, or if I falsify my "tobacco-free" status on this affidavit, I will be responsible for paying retroactive surcharges and may face disciplinary action up to and including termination of employment.

4. Cigna DENTAL Plans (Pre-tax):

☐ ***Opt-Out/Decline dental coverage for 2020**

MGMT/SUPV/PROF	Cigna Dental Care DHMO**	Cigna DPPO
Tier of Coverage	Total	Total
Employee (EE) Only	☐ $0.00	☐ $0.00
Employee + Spouse/DP	☐ $0.00	☐ $0.00
Employee & Child(ren)	☐ $0.00	☐ $0.00
EE + Family (Spouse/DP + Child(ren))	☐ $0.00	☐ $0.00

5. UnitedHealthcare VISION Plan (Pre-tax):

☐ ***Opt-Out/Decline vision coverage for 2020**

Vision Plan
Total
☐ $2.29
☐ $4.38
☐ $4.64
☐ $7.18

Please identify whether you have a ☐ **Non-Tax Qualified DOMESTIC PARTNER** and contact Benefits/HR for a separate Enrollment Form.

6. DEPENDENT INFORMATION:

Please complete this section if you wish to add or delete a dependent. If you have any additional children to add or delete, mark here ☐ and list on a separate sheet, sign and staple it to this form. A copy of the supporting document(s) (i.e.: marriage certificate, birth certificate, DP Affidavit) is required.

Add	Delete	LAST NAME	FIRST NAME	SOCIAL SEC #	DOB MM/DD/YYYY	SEX M/F	Medical	Dental	Vision
		Spouse							
		Child							
		Child							
		Child							

The Standard City Paid Life Insurance - The City pays the full cost for 1 times the base salary as of January 1 of each year up to a maximum of $300,000 life insurance coverage for all active full-time, senior management fellows and temporary full-time employees. Imputed Income applies for salaries that exceed $50,000.

7. The Standard VOLUNTARY GROUP TERM LIFE INSURANCE (Post-tax and Subject to Evidence of Insurability)***:

A: Additional Coverage Desired For Employee - Employees may apply for life insurance coverage in increments of $5,000 within a range of $10,000 (minimum) to $400,000 (maximum). (Please select one)

☐ ***Opt-Out/Decline** ☐ **$_______,000**

B: Coverage Desired For Spouse/DP - Spouse/DP qualifies for $5,000 to $200,000 in $500 increments but not to exceed 50% of employee's additional coverage. (Please select one)

☐ ***Opt-Out/Decline** ☐ **$_______,000**

C: Coverage Desired For Child(ren) to the end of the calendar year in which they turn Age 26. (Please select one)

☐ ***Opt-Out/Decline** ☐ **$10,000**

In accordance with the conditions of the Group Policy listed above, I hereby revoke any previous designations of primary beneficiary (ies) and contingent beneficiary (ies) (if any) and designate as primary beneficiary (ies) and contingent beneficiary (ies) (if any) in the event of my death, the following:

8. GROUP TERM AND AD&D LIFE INSURANCE Primary Beneficiary(ies) Designation – FOR EMPLOYEE COVERAGE ONLY:

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Required)	Address (Street, City, State, Zip Code)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL	100%

In the event said primary beneficiary(ies) predecease(s) me, I designate as contingent beneficiary(ies):

Contingent Beneficiary(ies) Designation – FOR EMPLOYEE COVERAGE ONLY:

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Required)	Address (Street, City, State, Zip Code)	Share%
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL	100%

9. Benefits Outsource Inc. FLEXIBLE SPENDING ACCOUNTS (FSA) (Pre-tax):

Complete this section if you wish to participate in either or both Flexible Spending Accounts for 2020 by entering the **ANNUAL DOLLAR AMOUNT**. **Participation does NOT carryover** from the previous year; **YOU MUST RE-ENROLL** during open enrollment. **The minimum you may contribute to either FSA account is $260 annually.**

☐ ***Opt-Out/Decline flexible spending account(s) coverage for 2020**

A. HEALTH Flexible Spending Account – A pre-taxed benefit used for eligible healthcare expenses for you, your spouse and your eligible dependents. **($2,700 Annual Maximum)**

$

B. DEPENDENT CARE Flexible Spending Account - A pre-taxed benefit used to pay for eligible dependent care expenses for children under the age of 13 or adult daycare. **($5,000 Annual Maximum)**

$

10. ARAG VOLUNTARY LEGAL INSURANCE (Post-tax):

☐ ***Opt-Out/Decline voluntary legal coverage for 2020**

Ultimate Advisor ☐ **$8.42** **Ultimate Advisor Plus** ☐ **$10.15**

If you would like this form in an alternate format or if you need reasonable accommodation to participate in this event, please call Benefits, HR (954) 828-5160 or email benefits@fortlauderdale.gov.

IMPORTANT TERMS AND CONDITIONS

- I authorize my employer to deduct from my pay the cost of any pre or post-tax benefits I have elected. I understand the contribution to my Social Security account may be reduced for pre-tax contributions based on my income after reduction.
- I agree for myself and covered members of my family to be bound by the benefits, deductibles, co-payments, exclusions, limitations and other terms of the Contracts, Agreements, and Plan Documents. I understand that my Group Health premiums will automatically be paid tax-free through salary reduction. Any premium attributable to a domestic partner (DP) and their child(ren) after the end of the calendar year that they turn age 26 will be post tax and subject to imputed income tax.
- I certify that the information supplied in this application is true to the best of my knowledge.
- I understand that once this form is submitted, I cannot request a change of medical, dental or vision plans until the next annual open enrollment. A change of coverage type may be requested to add a newly acquired dependent within 30 days of the event (60 days for newborns, adopted/placed for adoption), or to add or delete existing dependents subject to the requirements of the Internal Revenue Code Section 125 and the City's Flexible benefits Plan document or for certain Special Enrollment Rights such as loss of Medicaid/Child Health Insurance Program (CHIP) or eligibility for Premium Assistance/Child Health Insurance Program (CHIP). Please refer to the Employee Benefits web page or plan specific governing documents for more information.
- I understand that eligible married or unmarried, natural children (whether or not they live with the employee), children of a domestic partner, adopted children, stepchildren may be covered by the medical plan to the end of the calendar year in which the child turns 26. Proof of eligibility must be submitted to the Benefits Section. For unmarried children who satisfy the criteria under Florida Statute 627.6562, medical coverage may also be extended to the end of the calendar year in which the child turns 30. **Note:** For the dental and vision plans the limiting age for unmarried dependent children is age 26 (end of the calendar year). Physically or mentally disabled dependents may continue coverage beyond the limiting age, upon receipt of acceptable medical evidence as requested by the plans. Employees must contact the plan regarding extension of benefits for disabled dependents.
- I understand for ALL dependents to be enrolled, legal documents (example: marriage certificate, birth certificate, Affidavit of domestic partnership, etc.) must be attached to this form and submitted to the Benefits Section. Include your employee ID number on all dependent documentation submitted.
- I hereby acknowledge and certify that I have received and read the "City of Fort Lauderdale 2020 Benefits Open Enrollment Newsletter" and I am aware that the "2020 Benefits Handbook" and "City of Fort Lauderdale 2020 Open Enrollment Benefits Newsletter" are available for review on LauderShare and online at www.fortlauderdale.gov/benefits.

IMPORTANT NOTICES

***Opting-Out or Cancelling Coverage**: If you opt-out or cancel coverage, you cannot re-apply until the next open enrollment, unless you experience an Internal Revenue Code (IRC) Section 125 qualifying event or Special Enrollment Rights. Even if you decide not to select medical coverage, you MUST complete item #1 on page 1, check the opt-out/decline box, sign the form and return to the Benefits Section. The Affordable Care Act (ACA) requires employers to keep a record of eligible employees offered medical coverage even if they choose not to enroll for medical coverage.

****DHMO Dental Provider Name and #**: Please contact Cigna directly with the name and provider # of the participating dentist selected.

*****Voluntary Group Term Life Insurance:** I understand that if this application is received after 30 days of initial eligibility, or if coverage is in excess of the guaranteed issued amount, or if I increase my current coverage amount(s), evidence of insurability will be required by the current Group Carrier and is subject to medical approval. I must be actively at work for coverage to take effect. I authorize the City of Fort Lauderdale to provide a complete copy of this Group Term, Accidental Death and Dismemberment (AD&D) Life Enrollment and Beneficiary Designation Form, including my social security number, to the life insurance provider for the purpose of processing life insurance claim(s).

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Florida Statute Section 817.234 (1) (b)

11. MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND AGREE TO THE STATEMENTS, TERMS AND CONDITIONS PROVIDED ON THIS ELECTION FORM.	
Employee's Signature	**Date**

For Internal Use Only:

Received By	**Date**

All enrollment changes must be received by Benefits Section, HR by 11/08/2019. Change requests received after November 8, 2019 will not be processed. **Four (4) ways to submit this completed form (and any required documents) (DO NOT EMAIL):**

1. Meet with a Professional Benefits Counselor/Enroller. (Retain a copy, stamped by the Enroller, as proof of receipt)
2. Fax to: 954-828-5328 (Retain a copy of the fax confirmation)
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   100 N Andrews Ave 3rd Floor
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For questions, please contact Benefits Section, HR at 954-828-5160.

Please keep a copy of this completed form for your records.

Check the deductions on your January 3, 2020 paycheck and report any discrepancies no later than January 10, 2020.