City of St. Augustine
Enrollment & Change Form

Name (Last, First MI)	**SSN**	**Birth Date**	**Phone**	☐ **Male** ☐ **Female**
Street Address (Mailing)	**City**	**State**	**Zip Code**	☐ **Single** ☐ **Married**
Reason for change	**Type of change**	**Hire Date**	**Effective Date**	

Please make your benefits elections below by marking your election with an (X).

Medical, Vision, Dental, & Optional Life

Coverage Type	**Medical**	**Vision** (must be equal to or lower than medical option)	**Dental**	**Optional Life**
Employee Only	☐	☐	☐	☐
Employee & Spouse	☐	☐	☐	☐
Employee & Child(ren)	☐	☐	☐	☐
Family	☐	☐	☐	☐

DEPENDENT INFORMATION- Please provide information on all dependents for which you are electing coverage

Name (Last, First, & Middle initial)	**Relationship**	**SSN**	**Gender**	**Date of Birth**	**Coverage Requested (X)**	**FT Student?**
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No
			☐ Male ☐ Female		☐ Medical ☐ Dental · Vision ☐ Vol Life	☐ Yes ☐ No

VOLUNTARY OPTIONAL LIFE INSURANCE

☐ I do not wish to make changes to the coverage amounts of voluntary life for myself, spouse, and/or dependents from the in force amounts.

Coverage Type			**Amount of Coverage Requested**
Employee 1x – 5x Salary to Max GI $120,000*	☐ Elect	☐ Waive	$
Spouse Max $25,000*	☐ Elect	☐ Waive	$
Child(ren)	☐ Elect	☐ Waive	**$10k From 14 days to Age 25**

***You must complete an Evidence of Insurability (EOI) form if electing Voluntary Life coverage amounts in excess than the Guarantee Issue (GI) amount listed above. If you have elected an amount that requires completion of the EOI form, please see Human Resources. Deductions for elections over the Guarantee Issue amount are not taken until the EOI is reviewed and approved by Carrier.**

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EMPLOYER PAID LIFE INSURANCE – Below Class to be Completed by Human Resources

☐ **Class 1 $50k Life** | ☐ **Class 2 $10k Life + 1x Salary Life**

Primary Beneficiaries

Name (Last, First)	Relationship	%	Address	Phone #	SS#
1.					
2.					
3.					

Contingent Beneficiaries

Name (Last, First)	Relationship	%	Address	Phone #	SS#
1.					
2.					

Premium Only IRS Code Section 125

I understand that if my required premium contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

I understand that:

- I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have changes in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I take an unpaid leave of absence, a substantial change in family's health coverage due to change in my spouse's employer sponsored health coverage, etc.). *Notícfication of change must be within 30 days of the qualifying event.*
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.
- I hereby authorize my employer to reduce my cash compensation by the amount(s) indicated for each pay period during the plan year following the date on which this agreement is signed.
- I understand that my election may impact my future Social Security benefits.

I have read and understand this agreement and to the best of my knowledge it is true, correct and complete. 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.

Employee Signature	**Date**
x	x
Employer Signature	**Date**
x	x