2018 EMPLOYEE BENEFITS ENROLLMENT FORM

HR Use Only
Hire Date: _____
Entered: _____

☐ **OPEN ENROLLMENT** ☐ **BENEFIT CHANGE**

SECTION 1 – EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Birth Date (Mo/Day/Yr)	Kronos Number

Social Security Number	Work Phone Number	Home Phone No.

Address	City	State	Zip

SECTION 2 – DEPENDENT INFORMATION *(**Complete for each eligible dependent covered on your plan**. If dropping coverage, please complete Section 5.)*

☐Add ☐Drop	Spouse Name (First name, Last name)	Social Security Number	Birth Date	Gender ☐M ☐F
☐Add ☐Drop	Child Name (First name, Last name)	Social Security Number	Birth Date	☐M ☐F
☐Add ☐Drop	Child Name (First name, Last name)	Social Security Number	Birth Date	☐M ☐F
☐Add ☐Drop	Child Name (First name, Last name)	Social Security Number	Birth Date	☐M ☐F
☐Add ☐Drop	Child Name (First name, Last name)	Social Security Number	Birth Date	☐M ☐F

Are you applying due to a Qualifying Life Event? (Enrollment & supporting documentation must be provided within 31 days of the event)

☐Birth of a Child ☐Change in Marital Status ☐Loss/Gain of Coverage ☐Other _____

SECTION 3 – COVERAGE SELECTION

A. MEDICAL PLAN – UnitedHealthcare (*Prescription Coverage provided through Express Scripts, Inc.)*

Select a Plan	***Select an Option***	
	PPO ECONOMY	**EPO**
☐ PPO ECONOMY	☐ Employee Only	☐ Employee Only
☐ EPO	☐ Employee + Spouse	☐ Employee + Spouse
	☐ Employee + Child(ren)	☐ Employee + Child(ren)
	☐ Employee + Family	☐ Employee + Family

☐ ***I Decline Medical Coverage** (Must Provide Proof of Other Coverage)*

B. DENTAL PLAN - UnitedHealthcare	C. VISION PLAN - UnitedHealthcare
☐ Employee Only	☐ Employee Only
☐ Employee + Spouse	☐ Employee + Spouse
☐ Employee + Child(ren)	☐ Employee + Child(ren)
☐ Employee + Family	☐ Employee + Family
☐ ***I Decline Dental Coverage***	☐ ***I Decline Vision Coverage***

D. FLEXIBLE SPENDING ACCOUNTS (FSA) - UnitedHealthcare

☐MEDICAL FSA	$_____	(MIN $240 – MAX $2,600 PER PLAN YEAR)	☐I Decline Coverage
☐DEPENDENT CARE FSA	$_____	(MIN $240 - MAX $5,000 PER PLAN YEAR)	☐I Decline Coverage

(The annual elected amount will be deducted on a bi-weekly basis, in 24 pay periods.)

SECTION 4 – MEDICARE INFORMATION

1. Name of Person Covered	Medicare A (Hospital) Effective Date	Medicare No. (From Medicare Card)
	Medicare B (Medical) Effective Date	

Please check the reason for Medicare Eligibility

___ Entitled Age ___Disability ___End-Stage Renal Disease ___Disability and Current Renal Disease

2. Name of Person Covered	Medicare A (Hospital) Effective Date	Medicare No. (From Medicare Card)
	Medicare B (Medical) Effective Date	

Please check the reason for Medicare Eligibility:

___ Entitled Age ___Disability ___End-Stage Renal Disease ___Disability and Current Renal Disease

SECTION 5 – DECLINATION OF HEALTH COVERAGE

☐ This is to certify the available coverage has been offered to me and my eligible dependents. I have been given the opportunity to apply for the coverage offered and have voluntarily elected to decline the coverage as indicated below. **I understand that to decline employee coverage, I must attach proof of other health insurance coverage**. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

	Reason for Declining			
Name of Employee:	Other Group Coverage ☐	Medicare ☐	Medicaid ☐	Other ☐
Name of Spouse:	Other Group Coverage ☐	Medicare ☐	Medicaid ☐	Other ☐
Name of Child:	Other Group Coverage ☐	Medicare ☐	Medicaid ☐	Other ☐
Name of Child:	Other Group Coverage ☐	Medicare ☐	Medicaid ☐	Other ☐

If reason for declining is "Other", please explain reason:

COVERAGE CONDITIONS, SALARY REDUCTION AGREEMENT AND CAFETERIA PLAN ELECTION

- I have reviewed the terms of the San Antonio Water System Health and Welfare Benefit Plan ("Health and Welfare Benefit Plan"), which provides medical, dental, and vision coverage. I understand that I may elect any or all of these types of coverage, and that if I elect medical, dental and/or vision coverage I must do so by entering into a salary reduction agreement under the San Antonio Water System Cafeteria Plan (the "Cafeteria Plan"), whose terms I have also reviewed.
- I have also reviewed the terms of the SAWS Medical Flexible Spending Account Plan ("Medical FSA") and the SAWS Dependent Care Spending Account Plan ("Dependent Care FSA", and collectively with the Medical FSA, the "FSA Plans"). I understand that I may elect to participate in one or both of the FSA Plans by entering into a salary reduction agreement under the Cafeteria Plan.
- On behalf of myself and any others listed on this enrollment application, I apply for the selected coverage and hereby elect under the Cafeteria Plan for SAWS to reduce my salary in the amount of the selected coverage. I understand that:
    1. I may not revoke or change my salary reduction agreement under the Cafeteria Plan during the plan year unless I qualify for and have properly requested a change in status or experience another event that allows an election change, as described in the Cafeteria Plan;
    2. If I elect under the Cafeteria Plan to receive medical, dental or vision coverage, this election will be deemed to carry over for subsequent years unless and until I make a new election in an open or special enrollment period, and that my salary will continue to be reduced to pay for such coverage even where the cost of such coverage has changed; and
    3. My current elections for the FSA Plans, if any, will expire at the end of this Plan Year if I do not make a new election during the next open enrollment period.
- With respect to claims, I understand and agree that:
    1. Substantiation requirements apply to all claims submitted for reimbursement under the FSA plans and I will provide documentation as requested;
    2. I will use the FSA Debit Card for eligible expenses only and retain all itemized receipts/statements;
    3. I will read and adhere to the cardholder statement I receive with the card and I understand the card is subject to inactivation if I do not comply with the provisions;
    4. If a claim is erroneously paid under the FSA Plans for ineligible expenses, I must repay the amount of such ineligible claim, and if I do not make repayment then my employer may deduct the amount of the ineligible claim from my paycheck; and
    5. I may roll over up to $500 of my unused Medical FSA balance to the subsequent plan year, provided I elect a Medical FSA for the subsequent year to roll over the unused amount; otherwise, I will forfeit any balance remaining in my Medical FSA or my Dependent Care FSA for which reimbursement for expenses incurred during the plan year is not sought within 90 days of the close of the plan year.
- I understand that failure to pay the monthly premiums will result in cancellation of my coverage.
- I understand that if I cover my spouse on the medical plan, a spousal surcharge will be applied to my premium unless I submit a waiver form to HR Benefits. SAWS will not retroactively reimburse amounts already paid due to failure to submit a timely waiver.

Employee's Signature: _____ **Date:** _____

REVISED 08292017