Name:		Plan Year: 3/1/2018 Rates Effective: 3/1/2018
Address:		
City:	State: Zip:	
Phone:		Date of Hire:
Birthdate:		
SSN:		Type of Event: Open Enrollment

MEDICAL, VISION, DENTAL, LIFE, FSA ELECTIONS:

SELECT YOUR COVERAGE OPTIONS BY CHECKING THE BOX NEXT TO THE PLANS YOU ELECT:

COVERAGE TYPE	COVERAGE LEVEL	BI-WEEKLY CONTRIBUTION	SELECTION
Medical **Blue Care Network**	**Employee Only**	**$52.48**	
	Employee + Spouse	**$104.95**	
	Family	**$147.89**	
	I CHOOSE TO WAIVE THIS COVERAGE		
Dental **Delta Dental**	**Employee Only**	**$0**	
	Employee + Spouse	**$0**	
	Family	**$0**	
	I CHOOSE TO WAIVE THIS COVERAGE		
Vision **Eye Med**	**Employee Only**	**$0**	
	Employee + Spouse	**$0**	
	Family	**$0**	
	I CHOOSE TO WAIVE THIS COVERAGE		
Voluntary Life **Minnesota Life** **(subject to medical underwriting)**	**Employee**		
	Spouse		
	Dependent(s)		
	I CHOOSE TO WAIVE THIS COVERAGE		
Flexible Spending Account **Basic**	**Medical Reimbursement Account ($100/paycheck max)**		
	Dependent Care Account ($95/paycheck max)		
	I CHOOSE TO WAIVE THIS COVERAGE		

YOUR TOTAL BI-WEEKLY PRE-TAX COST/CONTRIBUTION $_____

Revised: December 17, 2018

Please sign below acknowledging your elections and that you have reviewed the new payroll deductions listed above for the benefit year beginning March 1, 2018.

SPECIAL ENROLLMENT RIGHTS

1. If you initially decline this plan's coverage for yourself and/or dependents because of other group health coverage, you may, in the future be able to enroll yourself and your dependents in the medical and/or dental plan if an election is made within 30 days after the other coverage ends.

EMPLOYEE AUTHORIZATION/CERTIFICAATION .

1. I have received, read, and understand the information explaining my benefit options.
2. I request membership in the plan I have elected on this form, for which I am eligible. I authorize the withholding of contributions from my pay.
3. I understand that by signing this form, I make a binding election concerning my benefits for the next year. I also understand that I will not be able to change my election prior to the next open enrollment period unless I have a qualified life event.
4. I understand my duty to notify the City of Center Line within 30 days of any changes that affected the eligibility of any of my covered dependents; for example, marriage, divorce, or change in student status.
5. I understand that enrolling a dependent who is not eligible or failing to provide notice of ineligibility can result in retroactive termination of health plan coverage for me/my dependents. I also understand that coverage of ineligible dependent will result in liability on my part for costs incurred while my dependent was ineligible.

EMPLOYEE SIGNATURE: _____DATE_____

EMPLOYER SIGNATURE: _____DATE_____