



Benefits Election/Change Form – Active Employees

January 1, 2017 – December 31, 2017

Check The Appropriate Box

Initial Enrollment, Marriage, Employment Status Change, Cancel Coverage, Open Enrollment, Birth / Adoption, Special Enrollment, Other

Employee Information

Last Name, First Name, Initial, Social Security Number, Location, Physical Street Address, Mailing Street Address, Home Telephone, Work Phone, Email Address, Date of Birth, Date of Hire, Effective Date, Marital Status, Sex

Benefit Elections

Table with columns: Full-Time Employees, CIGNA Medical, MetLife Dental, EDS* (AZ Only) Dental, UHC Vision. Rows include Employee Only, Employee + Spouse, Employee + Child, Employee + Family, Waive Medical, Waive Dental, Waive Vision.

Reason for Waiving Coverage:

*EDS Dental office selection for you and your enrolled dependents. ID Number: Name of office:

Please complete for each of your eligible dependents

Table with columns: Check Appropriate Box, First Name, Initial, Last Name, Social Security Number, Sex, Date of Birth, Relationship Type, Coverage Elected.

Eligible dependent coverage up to age 26 for Medical, Dental and Vision Coverage

Table for dependent coverage with columns: Check Appropriate Box, First Name, Initial, Last Name, Social Security Number, Sex, Date of Birth, Relationship Type, Coverage Elected.

(Over)

Other Coverage Information

On the day coverage begins will you or any of your eligible dependents be covered by any other insurance?

Yes No If yes, please complete the information below. Use an additional sheet if more than one additional policy will be in force.

Coverage <input type="checkbox"/> Medical / Medicare Type <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Insurance Company Name	Phone Number (____) _____ - _____	Group Number	Policy Number
	Policy Coverage Dates to _____	Policy Holder Name	Social Security Number _____ - _____ - _____	
Family Members Covered _____		Medicare Card Number	Effective Date Part A: ____/____/____ Part B: ____/____/____	

Flexible Spending Account Elections

If enrolling, fill in your election below and complete the HealthSmart Enrollment Form

Healthcare Spending Account

The amount you elect will be deducted in equal payments for the remainder of the calendar year.

Minimum Election: \$100 / Maximum Election: \$2,600

Annual Election: \$ _____ Per Pay (____) Deduction \$ _____

Limited Purpose Healthcare Spending Account

Minimum Election: \$100 / Maximum Election: \$2,600

Annual Election: \$ _____ Per Pay (____) Deduction \$ _____

Limited Purpose FSA is a reimbursement account specifically designed for individuals with a Health Savings Account (HSA). The IRS regulations state that an individual with an HSA cannot simultaneously have a general purpose FSA. However, they are allowed to participate in a limited purpose FSA. The difference between general FSA and Limited Purpose FSA is the eligible expenses. A Limited Purpose FSA plan only allows for reimbursements of Preventive Care, Post Deductible Expenses, Dental, and Vision.

Dependent Care Spending Account

Minimum Election: \$100 / Maximum Election: \$5,000 or \$2,500 (married filing separately)

Annual Election: \$ _____ Per Pay (____) Deduction \$ _____

Health Savings Account Elections

If enrolling, fill in your election below and complete the AURA HSA Contribution Form

Maximum Single Election \$3,400

Maximum Family Election \$6,750

Includes employer and employee contributions

Catch Up Contribution - Policy Holders age 55 or older can contribute an additional \$1,000

Health Savings Account Annual Election: \$ _____ Per Pay (____) Deduction \$ _____

Voluntary Life and AD&D Insurance Elections

If enrolling, fill in your election below and complete the CIGNA Voluntary Life Application if you elect over the Guarantee Issue Amount

If you enroll within 31 days of your initial eligibility, you are eligible to elect up to the Guarantee Issue amount without providing evidence of good health. If you did not enroll for Voluntary Life within 31 days of your initial eligibility, you will need to provide evidence of good health in order to enroll.

During Open Enrollment, if you are currently enrolled for Voluntary Life under the Guarantee Issue Amount, you may increase your current amount by \$10,000 not to exceed Guarantee Issue without providing evidence of good health.

Coverage Type	Supplemental Life Amount Elected	Supplemental AD&D Amount Elected	No Change	Waive
Employee Coverage	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Spouse Coverage	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child(ren) Coverage	\$ _____	N/A	<input type="checkbox"/>	<input type="checkbox"/>

Certification and Authorization

I certify that all information on this form is true and complete to the best of my knowledge.

I understand that my Medical, Dental and Vision premiums and my Flexible Spending Account and/or Health Savings Account contributions will be deducted Pre-Tax.

- I may benefit from a decrease in my tax liability, however my payments into the Social Security System and my benefits under Social Security may also be reduced;
- During the course of the Plan Year (1/1/17 to 12/31/17), I may not increase, decrease, or eliminate any pre-tax payroll-deducted premiums unless I experience a related "change in status". Examples include marriage, divorce, death of spouse or child, birth or adoption of a child, loss of other coverage, or termination of your spouse's employment.

If you would prefer Post-Tax deductions please see Human Resources.

I understand that for Life and AD&D Insurance I must be actively at work in order for coverage to take effect and that coverage must be approved by CIGNA.

I authorize deductions for the required contributions from my earnings.

EMPLOYEE SIGNATURE:	DATE:
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