



Benefits Election/Change Form – Gemini Active

January 1, 2019 – December 31, 2019

Check The Appropriate Box			
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Marriage ____/____/____	<input type="checkbox"/> Employment Status Change ____/____/____	<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Birth / Adoption ____/____/____	<input type="checkbox"/> Special Enrollment ____/____/____	<input type="checkbox"/> Other _____

Employee Information			
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Last Name	First Name	Initial	Social Security Number ____-____-____
Location: Gemini North			
Physical Street Address	City	State	Zip Code
Mailing Street Address	City	State	Zip Code
Home Telephone (____) _____ - _____	Work Phone (____) _____ - _____	Email Address	
Date of Birth ____/____/____	Date of Hire ____/____/____	Effective Date ____/____/____	Marital Status
			Sex

Benefit Elections					
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Full-Time Employees Refer to the Benefits Guide for Rates	HMSA Medical		Kaiser Medical		HSMA Dental	
	HMO	PPP	HMO	POS	DHMO	DPPO
	Policy #72764-1		Policy #4595		Policy #72764-1	
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + Spouse (One Dependent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Waive Medical <input type="checkbox"/>				Waive Dental <input type="checkbox"/>	

Reason for Waiving Coverage:

Please complete for each of your eligible dependents					
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Check Appropriate Box	First Name, Initial, Last Name	Sex	Date of Birth	Relationship Type	Coverage Elected
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	Social Security Number SS# ____ - ____ - _____		____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Med <input type="checkbox"/> Den <input type="checkbox"/>

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

<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# ____ - ____ - _____		____/____/____		Med <input type="checkbox"/> Den <input type="checkbox"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# ____ - ____ - _____		____/____/____		Med <input type="checkbox"/> Den <input type="checkbox"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# ____ - ____ - _____		____/____/____		Med <input type="checkbox"/> Den <input type="checkbox"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# ____ - ____ - _____		____/____/____		Med <input type="checkbox"/> Den <input type="checkbox"/>
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# ____ - ____ - _____		____/____/____		Med <input type="checkbox"/> Den <input type="checkbox"/>

(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 Type <input type="checkbox"/> Medical / Medicare <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: \$2,700
 Annual Election: \$ _____ Per Pay (____) Deduction \$ _____

Dependent Care Spending Account
 Minimum Election: \$100 / Maximum Election: \$5,000 or \$2,500 (married filing separately)
 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"/>

Voluntary Worksite Benefits Elections

Accidental Injury Insurance	Critical Illness Insurance	Hospital Care Indemnity Insurance
<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
<input type="checkbox"/> Employee Only	Benefit Amount (Select One) Select Tier	<input type="checkbox"/> Employee Only
<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> \$5,000 <input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse
<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> \$10,000 <input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)
<input type="checkbox"/> Employee + Family	<input type="checkbox"/> \$20,000 <input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family
	<input type="checkbox"/> Employee + Family	
	Have you or a dependent to be enrolled in the 5K, 10K, or 20K Voluntary Critical Illness Insurance plan used Tobacco products in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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 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 (1/1/19 to 12/31/19), 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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