UMR

Employee Enrollment / Change Form

☐ Initial Group ☐ Open Enrollment

☐ New Employee ☐ Change (complete change section on reverse side)

Benefits Administered by:
UMR - ENROLLMENT SERVICES
PO BOX 8052 WAUSAU, WI 54402-8052

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE START DATE	EFFECTIVE DATE
City of Michigan City	76-413646		

LOCATION (Select one)

☐ 001-City of Michigan City
☐ 002-City Clerk
☐ 003-City Attorney
☐ 004-Controller
☐ 005-Engineering
☐ 006-Maintenance
☐ 007-Planning/Inspection
☐ 008-Human Rights
☐ 009-Transit
☐ 010-Personnel
☐ 011-Central Services
☐ 012-Street Department
☐ 013-Fire Department
☐ 014-Police Department
☐ 015-Park and Recreation
☐ 016-Aviation
☐ 017-Golf
☐ 018-Barker Civic Center
☐ 019-Refuse Department
☐ 020-Vector/Animal Control
☐ 021-Central Maintenance
☐ 022-Sanitary District
☐ 023-Cemetery
☐ 024-Retiree's/Public Safety
☐ 025-Port Authority
☐ 026-Emergency Management
☐ 027-Water Department
☐ 099-COBRA

☐ ACTIVE
☐ RETIREE
☐ COBRA

SOCIAL SECURITY NUMBER ___ - ___ - ___ ALTERNATE IDENTIFICATION NUMBER

NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP EMAIL ADDRESS

DATE OF BIRTH / / GENDER ☐ M ☐ F MARITAL STATUS HOME TELEPHONE NUMBER ( )

Do you or any family member currently have other medical, dental or vision coverage? ☐ Yes, single ☐ Yes, family ☐ No

If yes to the above question, complete the following: ☐ Medical ☐ Dental ☐ Vision

Person's name _____ Employer Name _____

Carrier Name _____ Plan Number _____

MEDICAL COVERAGE

☐ PPO Plan
☐ QHDHP HSA Option 1
☐ QHDHP HSA Option 2

☐ Employee only
☐ Employee plus Spouse
☐ Employee plus Child(ren)
☐ Family

☐ Waive

STD COVERAGE

☐ Elected Officials or Department Head
☐ All Active Employee's

☐ Employee only

☐ Waive

	Last First MI	SS#	Birth Date	Gender	Relationship to Employee
Spouse Name				☐ M ☐ F	
Child Name		SS#	Birth Date	Gender	
1				☐ M ☐ F	
2				☐ M ☐ F	
3				☐ M ☐ F	
4				☐ M ☐ F	
5				☐ M ☐ F	

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____ **Please specify change and update in appropriate section.**

- ☐ Employee name change
- ☐ Employee address change
- ☐ Job location change
- ☐ Job title change
- ☐ Return to work
- ☐ Other coverage change
- ☐ Date of Marriage_____
- ☐ Date of Divorce_____
- ☐ Other _____
- ☐ Eligible for Medicaid/CHIP subsidy
- ☐ Loss of Eligibility for Medicaid/CHIP subsidy
- ☐ Add dependents
- ☐ Remove dependents (list names) _____ Reason: _____
- ☐ Add coverage
- ☐ Voluntarily Terminate coverage (Indicate which coverages)_____
- ☐ State/Federal Continuation

Employee Signature Required

☐ Employment termination: Reason:_____ Last day worked_____Date coverage terminated_____

WAIVING COVERAGE

Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:

☐ I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language contact your Human Resources Representative

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

_____ _____

EMPLOYEE SIGNATURE DATE

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____ _____

EMPLOYEE SIGNATURE DATE

Person Proposed for Insurance *(first, middle and last name)*	Gender	Date of Birth *(mm/dd/yyyy)*	Social Security Number	Covered by employee's major medical plan?	Coverage Election		
						Dental	
Spouse	☐ Male ☐ Female	/ /		☐Yes ☐ No		☐	
Child	☐ Male ☐ Female	/ /		☐Yes ☐ No		☐	
Child	☐ Male ☐ Female	/ /		☐Yes ☐No		☐	
Child	☐ Male ☐ Female	/ /		☐Yes ☐No		☐	

- *Waivers are not allowed for non-contributory coverages*

** Note: Spouse includes the Proposed Insured's legally married spouse as recognized in the governing jurisdiction.*

[For additional children, please attach a separate sheet of paper signed by the Proposed Insured, including the above information for each child.]

SECTION 8 ACKNOWLEDGEMENTS

By signing this Enrollment form, I understand and agree that:

(1) I authorize my Employer to make required deductions, if any, from my salary to pay the premium for my insurance as elected above once in effect.

(2) All statements and answers I have given are complete and true to the best of my knowledge and belief.

(3) Coverage is not in effect until final approval is given by the Company[1].

(4) No person, except an officer of the Company, is authorized to vary or modify a contract.

(5) I have read and acknowledge the applicable fraud warning attached.

(6) I, the undersigned agree that statements and answers in all parts of the enrollment form are true and complete to the best of my knowledge and belief.

SECTION 9 EMPLOYEE WAIVER OF INSURANCE

☐ I have been given the opportunity to apply for the group insurance plan coverage as presented to me, but do **NOT** wish to enroll in the insurance plans offered. Coverage offered by my Employer and not elected in the Insurance Coverage Election portion of this form is assumed to be coverage that I have refused. No waivers are allowed for non-contributory coverage. I understand that if I or my dependents decide to apply for this group insurance plan at a later date, Late entrant penalty and/or Evidence of Insurability will be required at my own expense. The Evidence of Insurability must be approved by the Company.

Sign Here

Employee/Applicant Signature **Date**

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

Regular and Express Mail:
Equitable Employee Benefits
8501 IBM Drive Suite 150-B
Charlotte, NC 28262

EQUITABLE *

Group Employee Benefits
Enrollment Form/Change Form

For Assistance Call (866) 274-9887

Email: EB_Enrollment@equitable.com

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America

SECTION 1 PROPOSED INSURED INFORMATION - PLEASE PRINT USING DARK INK

Employer Name and Address **City of Michigan City** **100 E Michigan Blvd, Michigan City, IN 46360**					
Group Number# 021807	Class#	Dept/Loc#		Effective Date	
Employee Name *First, MI, Last*	Social Security Number (SSN)	☐Male ☐ Female		☐Single ☐ Married**	Date of Birth (DOB) *(mm/dd/yyyy)*
Home Address	City	State	Zip	County /Worksite Zip	
Job Title	Annual Salary	Hours Per Week		Date of Hire	
Email Address		Phone number			

Status Change
☐ Active FT EE

☐ Retiree

COVERAGE(S) ELECTED
Please check the applicable insurance coverage(s) you are electing.
NOTE: If you are declining coverage offered by your Employer, please complete the Employee Waiver of Insurance section of this form.

SECTION 4 COMPLETE THIS SECTION IF APPLYING FOR DENTAL PLAN DESIGN COVERAGE OPTIONS

☐ Dental ☐ Low Plan ☐ High Plan	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Spouse + Child(ren) ☐ Waive*

If waiving* Dental coverage, please check one of the following:

- ☐ I have (dental) coverage through my spouse.
- ☐ I have other (dental) coverage.
- ☐ I do not have other (dental) coverage.

- * Waivers are not allowed for non-contributory coverage.
- ** *Note: Spouse includes the Proposed Insured's legally married spouse, or civil union partner or domestic partner if legally recognized in the governing jurisdiction*

SECTION 6 SPOUSE AND DEPENDENT CHILDREN INFORMATION (COMPLETE IF PROPOSED INSURED IS APPLYING FOR DEPENDENT'S COVERAGE).

City of Michigan City
MetLife Enrollment Form - Vision

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.	EE ID:	Group Policy #: 5394302	Billing Division or Location:

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name	County	Employer ZIP	State
CITY OF MICHIGAN CITY		46360	INDIANA

Employee First Name / Middle Initial / Last Name	Social Security Number	Date of Birth

Street Address	City	State	Zip

Gender:	Marital Status:	Home Phone	Work Phone	Email Address:

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Full-Time Employment Date:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Cost per Pay
Vision Provided By: MetLife	☐Yes ☐No*	☐Employee Only ☐Employee/Spouse ☐Employee/Children ☐Employee/Spouse/Children	$5.00 $10.00 $10.00 $10.00

*By selecting no, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense

– Actual deductions may vary slightly from above illustration due to rounding –

Dependent and Other Insurance Information (Complete for Dependent Coverage)

	Last Name	First Name	Gender	Date of Birth	Social Security #
Spouse:					
Child:					
Child:					
Child:					

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature Section:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name: _____

Employee Signature: _____ **Date:** _____

Dearborn National

Underwritten by Dearborn National® Life Insurance Company

BENEFICIARY DESIGNATION FORM

Return to Dearborn National at:
Attention: Claims Department
P.O. Box 7070
Downers Grove, IL 60515

INSTRUCTIONS (PLEASE PRINT. SIGN AND DATE THIS FORM IN BLACK INK)

Employee/Retired Employee Name	SSN	Date of Birth	Home Telephone Number

Home Address	City	State	Zip

Employer	Group Number

Irrevocable Beneficiary: ☐ Yes ☐ No

Note: If you select irrevocable beneficiary, you may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract, therefore the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

DEFINITIONS & STATEMENTS

Primary Beneficiary means the person or persons who will receive the benefits in the event of the Insured's death. Proceeds will be divided in equal shares if multiple primary beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%.

Contingent Beneficiary means the person or persons who will receive the benefits if the primary beneficiary is not living at the time of the Insured's death.

Will or Trust as Beneficiary Designation can be done by using the following written statement: "*To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust].*" If you wish to designate a testamentary trust as beneficiary (i.e. created by will), you should recognize the possibility that your will which was intended to create a trust may not be admitted to probate (because it is lost, contested or suspended by a later will). Claim payment delays can result if the beneficiary designation does not provide for this situation. **

Minors as Beneficiary Designation can be done by using this document. However, please note if your beneficiary is a minor at the time of claim, payments may be delayed due to special issues raised by these designations. **

Dependent Beneficiary – In the event a dependent dies, the employee is the beneficiary of their life insurance proceeds.

**You may want to obtain the assistance of an attorney to help consider any special circumstances before drafting your beneficiary designation.

BENEFICIARY DESIGNATION FOR ALL EMPLOYEE/RETIRED EMPLOYEE LIFE BENEFITS

Primary Beneficiary	Birth Date	Relationship	Social Security #	Address	%
Contingent Beneficiary	**Birth Date**	**Relationship**	**Social Security #**	**Address**	**%**

WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

Employee/Retired Employee Signature_____ **Date**_____

Important Note For Married Employees: If you live in a community property state/territory, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states/territories currently include: AZ, CA, GU, ID, LA, NM, NV, PR,TX, WA and WI. Payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. **DEARBORN NATIONAL WILL NOT BE LIABLE FOR DAMAGES DUE TO ANY DELAY OR DISPUTE IN PAYMENT OF BENEFITS IF YOU CHOOSE NOT TO OBTAIN YOUR SPOUSE'S SIGNATURE.**

Spousal Consent for Community Property States/Territories: I hereby consent to the Primary Beneficiary designated by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature _____ Date _____ ☐ Employee has no legal spouse

CITY OF MICHIGAN CITY EMPLOYEE BENEFIT PLAN

SECTION 125 ENROLLMENT FORM

EMPLOYEE NAME_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

SOCIAL SECURITY #_____

SALARY REDUCTION AGREEMENT

I authorize the reduction of my salary on a pre-tax basis for insurance premiums and reimbursement accounts eligible under Section 125 of the Internal Revenue Code. This may include premiums for health, dental and vision coverage, flexible spending account, health savings account and other eligible voluntary insurance premiums. I understand that this amount will be deducted equally from the first two pay periods of each month within the Plan Year. Further, I understand that this election is irrevocable during the Plan Year unless the revocation qualifies as a change in family status as defined in the Plan.

PLAN ELECTION

_____ No. I have been given the opportunity to enroll in this plan, but I do not wish to participate during this plan year.

_____ Yes. I wish to participate in the Section 125 Plan.

_____ _____

EMPLOYEE SIGNATURE DATE