CITY OF MILPITAS BENEFITS ENROLLMENT FORM

First	Last	Social Security Number

Mailing Address- Street	City	State	Zip
Home Phone	Department Name	Union	Work Phone

Date of Birth	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Domestic Partner

ACTION(S) TO BE TAKEN

☐ New Enrollment Effective date:_____

☐ Change Plan State Reason:_____

☐ Add Eligible Dependent, State Reason: _____

☐ Cancel Plan, State Reason: _____

☐ Open Enrollment

☐ Changes to Flexible Spending Account

☐ Remove Dependent State Reason: _____
(in case of divorce, you must provide a copy of final decree)

Medical Waiver (Cash in Lieu) (474)

☐ Receive Medical Waiver in lieu of Health Insurance. Monthly reimbursement $125

A separate enrollment form is required. You will need to provide name, policy/group number of alternate health insurance. A copy of your health insurance card is also required.

Flexible Spending Accounts (FSA)

I authorize payroll deductions as follows:

☐ Health Care Account (305-2) Annual Amount

☐ Dependent Care Account (305-1) Annual Amount

☐ Transportation /Parking (305-5) Annual Amount

Reimbursement Account Fee (306-2) T/P Account Fee (306-6)

List eligible dependents to be enrolled including yourself. To enroll a spouse or domestic partner, you must provide evidence of marriage or state approved declaration of domestic partnership. A copy of birth certificates for is required for all dependent children. Please provide social security numbers of all dependents.

Name	Date of Birth	Relationship	Social Security	Dental Add	Dental Delete	Vision (835) Add	Vision (835) Delete
		SELF					

☐ PD Dental Single (855-1) ☐ PD Dental Family (855-2) ☐ Fire Dental (857) ☐ Delta Dental Mics (858)

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Voluntary Life and AD & D (320)

☑ City Provided $50,000 (850)

☐ Voluntary Employee Amount $ _____
Evidence of Insurability is required for any amount exceeding the lesser of $80,000 or three times your annual salary for employees under age 70.

☐ Voluntary Spouse/Domestic Partner Amount $ _____
Evidence of Insurability is required for any amounts exceeding $10,000 for employees under age 60; Guaranty issue not available for employees over age 60.

☐ Voluntary Child Amount $ _____

☐ Waiving Employee Voluntary Life Coverage

☐ Waiving Spouse/Domestic Partner Voluntary Life Cvg

☐ Waiving Child Voluntary Life Coverage

MPOA Trust (891)

Short Term Disability (840)

EMPLOYEE: _____ **/ $1,000 =** _____ **x** _____ **= $** _____
Elected Benefit Amount — Rate — Employee Monthly Cost

SPOUSE/DP: _____ **/ $1,000 =** _____ **x** _____ **= $** _____
Elected Benefit Amount — Rate — Spouse/Domestic Partner Monthly Cost

Long Term Disability

☐ Misc. (845) ☐ Fire (846) ☐ PD (847)

Long Term Disability Buy Up Option (315)

10,000 monthly maximum covered salary
60% of monthly earnings up to $6,000 maximum monthly benefit

_____ / 12 = _____ / 100 = _____ x _____ = $ _____
Annual Salary — * Monthly Salary — Rate per $100 — Employee Monthly Cost

*If monthly salary is greater than $10,000, use monthly salary as $10,000

Deduction Authorization

If applicable, I hereby authorize deductions from earnings of sufficient amounts for **ALL** elected coverage to cover my contributions toward benefit plans I have elected until revoked by me. I understand that my pre-tax earnings will be reduced each pay period by the amount of my contributions to coverage I have elected. I further understand that in the event of separation from employment, any portion of premiums not paid will be deducted from my last paycheck. In the event of any difference between any of the benefits listed on this enrollment form and any of the insurance policies offered by the City, I agree to be bound by the insurance policy and not this application.

_____ _____
Employee Signature — Date