

2015 BENEFITS ENROLLMENT FORM

HUMAN RESOURCES DEPARTMENT
900 Church Street, 3rd Floor, Lynchburg, VA 24504
FAX: (434) 845-4304 PH: (434) 455-4200

REASON: New Hire Open Enrollment (Eligible and Not Previously Covered)

EMPLOYEE INFORMATION

Name (first, middle, last):		Social Security Number:	
Address (street, city, state, zip code):		Date of Birth:	Hire Date: <input type="checkbox"/> Female <input type="checkbox"/> Male
Optional Contact Information	Phone:	Email:	

ENROLLMENT CHOICES AND MONTHLY COST

Medical: PCHP #52021 Rx: Script Care #004410	<input type="checkbox"/> Employee Only (\$0) <input type="checkbox"/> Employee + Spouse (\$214) <input type="checkbox"/> Employee + Child (\$178) <input type="checkbox"/> Employee + Children (\$325) <input type="checkbox"/> Employee + Family (\$385) <input type="checkbox"/> Family - Two Married City Employees (\$54)(Spouse _____) <input type="checkbox"/> Waive Coverage <input type="checkbox"/> Non-participants in Health Mgt Program (HMP) pay an additional \$42 in all choices Note: Dependent children eligible for Medical coverage until age 26
Dental: Anthem #033300	<input type="checkbox"/> Employee Only (\$0) <input type="checkbox"/> Employee +One Dependent (\$22) <input type="checkbox"/> Employee + Family (\$39) <input type="checkbox"/> Waive Coverage Note: Dependent children eligible for Dental coverage until age 23
Vision: Eye Med #9855883	Vision Coverage Available to HMP participants only. <input type="checkbox"/> Employee Only (\$0) <input type="checkbox"/> Employee + One Dependent (\$4) <input type="checkbox"/> Employee + Family (\$8) <input type="checkbox"/> Waive Coverage Note: Dependent children eligible for Vision coverage until age 26

DEPENDENT(S) ENROLLMENT ELIGIBILITY DOCUMENTATION REQUIRED FOR NEW MEMBERS*

Check All That Apply:				
Name	Date of Birth:	SSN	<input type="checkbox"/> Spouse	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Gender:			
Name	Date of Birth:	SSN	<input type="checkbox"/> Child (biological, adopted, step child living in your home, or for whom you have legal guardianship)	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Gender:			
Name	Date of Birth:	SSN	<input type="checkbox"/> Child (biological, adopted, step child living in your home, or for whom you have legal guardianship)	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Gender:			
Name	Date of Birth:	SSN	<input type="checkbox"/> Child (biological, adopted, step child living in your home, or for whom you have legal guardianship)	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Gender:			
Name	Date of Birth:	SSN	<input type="checkbox"/> Child (biological, adopted, step child living in your home, or for whom you have legal guardianship)	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Gender:			

***REQUIRED DOCUMENTATION:** Marriage Certificate Birth Certificate Adoption Certificate Court Order

DO YOU and/or YOUR DEPENDENTS HAVE OTHER INSURANCE COVERAGE YES (If yes, the following is required) NO

Name of Other Insurance:	Policy Number:
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I hereby apply for membership or request a change in membership and authorize the City of Lynchburg to deduct from my wages the amount required (if any) to cover my contributions(s) for medical, dental, and/or vision coverage. I understand that medical and dental dependent deductions will be withheld on a pre-tax basis unless I notify HR otherwise. I understand that as automatic renewal occurs, new rates may apply. I understand that my enrollment and benefits are in accordance with those described in the applicable plan document. If changes occur and my dependents become ineligible for coverage, I agree to notify HR within 31 days. I authorize 1) all health providers and insurers to furnish to PCHP/Script Care/Anthem Dental/Eye Med Vision Care and 2) all health providers' and PCHP/Script Care/Anthem Dental/Eye Med Vision Care to furnish to all insurers and health providers records concerning me or any members of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing the authorization for disclosure of information. A photographic or electronic copy of this authorization shall be as valid as the original.

Employee Signature	Date
Human Resources Signature	Coverage Effective Date