GROUP BENEFITS

City of Salem
Benefits Enrollment Form

Information about You

Name:	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:
Earnings:	Location/Department/Division:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

Step 1: Please **enter or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*

Step 2: Choose either pre-tax or after tax premium deduction.

Step 3: Please **sign, date and return** this form to Human Resources.

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Family Voluntary Accidental Death & Dismemberment Insurance

Family Member(s) Covered:	Employee Only	Employee & Spouse Only	Employee & Child(ren) Only	Employee, Spouse & Child(ren)
Percent of Benefit Paid:	100%	100% for Employee 50% for Spouse	100% for Employee 15% for each Child	100% for Employee 40% for Spouse 10% for each Child

Coverage Option:	Rate
Myself Only	$0.0410
Myself and My Family	$0.0530

To calculate your Monthly cost, please use the following formula(s):

_______________________÷ $1,000 =____________x__________________= $______________________

Elected Benefit Amount Rate My Monthly Cost

(Employee Coverage Amount Only)

☐ I elect to **purchase** $___________of AD&D coverage for myself only.

☐ I elect to **purchase** $___________of AD&D coverage for myself. My family will be covered at the percentages of my election listed above.

Please choose if you would like your premium to be taken pre-tax or after tax form your paycheck.

☐ I authorize my premium to be taken pre-tax, I have read the pre-tax agreement information

☐ I authorize my premium to be taken after tax

Pre-tax Agreement Information

I hereby elect and authorize the City of Salem to withhold from my salary or wages, on a pre-tax basis, the amount of my employee contributions for these benefits and to apply this amount towards the purchase of the benefits I have initialed above. I make this election and give this authorization with the following understanding: I acknowledge that this election is irrevocable and cannot be terminated or changed except as permitted by City of Salem policy and in accordance with and in compliance with Health Insurance Portability and Accountability Act and with IRS Regulations. I authorize the City of Salem to automatically increase or decrease the amount deducted from my salary to reflect changes in rates during the year. I acknowledge that my election and authorization may reduce payments for my Social Security Account. Should I have any questions about how this will affect my Social Security income, I understand that I should consult with my retirement or tax consultant.

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Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Name:____

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor. The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request. Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans. This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.
Signature of Employee's Spouse: ____ Date: _____________________________

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Accident Insurance coverage described in the Benefit Highlight Sheets and offered through City of Salem. I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy. If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition. I authorize my employer to make the appropriate payroll deductions from my earnings.
I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer.

Signed ____Date ____

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