



BENEFITS ENROLLMENT FORM

Health Benefits

Medical Coverage

**If electing dependent coverage, please complete the dependent information form.*

- Employee Only \$33.98
- Employee/Child(ren) \$113.93
- Employee/Spouse \$118.65
- Family \$142.39
- No Coverage – Complete the Waiver of Enrollment

Dental Coverage

- Employee Only \$7.57
- Employee/Child(ren) \$32.86
- Employee/Spouse \$34.22
- Family \$42.54
- No Coverage – Complete the Waiver of Enrollment

Flexible Spending Accounts

Dependent Care

- Annual Election \$ _____
- Per Pay Election \$ _____
- No Coverage

Health Care

- Annual Election \$ _____
- Per Pay Election \$ _____
- No Coverage

Flex Insurance

- Annual Election \$ _____
- Per Pay Election \$ _____
- No Coverage

Optional Life Insurance

The Standard Company
\$10,000.00 Single
\$13,000 Family

- Employee Only \$1.68 per pay
- Family \$3.14 per pay
- No Coverage

KPERS Coverage
(\$5,000 to \$300,000)

- Coverage \$ _____
- No Coverage

*KPERS Optional Life Coverage cost depends upon your age and the amount of coverage desired.



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By signing below, I hereby authorize the City of Pittsburg to withhold from my wages the total deductions, for health and welfare benefits, on a semi-monthly basis, which equals and is used for my share of the premium coverage I have selected. I understand this authorization revokes any previous salary reduction agreement. These deductions cannot be adjusted during the plan year unless I experience a change in family status or other qualifying event as described in Section 125 of the Internal Revenue Code.

Print Name

Employee Signature

Date

Please complete if you elect no coverage for Medical and/or Dental insurance.

WAIVER OF ENROLLMENT

The group insurance program has been offered to me and I am waiving my right to participate because:

Health

I am covered by my spouse or parent's insurance program, which includes:

- Health Only Dental Only Health and Dental

Spouse or Parent's Name: _____

Place of Employment: _____

Name of Insurance Company: _____

Plan ID #: _____

- I do not desire to enroll in Blue Cross and Blue Shield of Kansas coverage at this time and have no other insurance.
 Other coverage (i.e., Medicaid, Medicare): _____

Dental

- I do not desire to enroll in Blue Cross and Blue Shield of Kansas Dental coverage at this time and have no other insurance.

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the date of the event. Contact HR for assistance.

Print Name

Employee Signature

Date