2018 MEDICAL, DENTAL, VISION PLAN CHANGES (DEPENDENT ADDS OR DROPS)

Note: To be eligible for insurance coverage with the City, a dependent child must be under age 26 and must not be covered under their employer's insurance or be eligible for his/her employer's insurance.

Employee Name (Print) ______________________________ **Dept.** ________________

Change is for: ___**Medical Plan** ___ **Dental Plan** ___**VSP** ___ **Humana** **Effective Date:** __________

General Fund Dental Division Active: _____ D00
General Fund Dental Division Retiree: _____ D03
General Fund Medical Division Active: _____ 000
General Fund Medical Division Retiree: _____ 003

Utilities Dental Division Active: _____ D01
Utilities Dental Division Retiree _____ D04
Utilities Medical Division Active: _____ 001
Utilities Medical Division Retiree: _____ 004

Notes: ____

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Adding or Dropping Step, Legal Guardianship, or Adopted Children- Please add/drop the following dependent to my insurance. I certify that: 1.) I have legal custody of these children or they reside in my household; 2) we have a parent-child relationship 3) I am legally responsible for each child. Attach copy of adoption decree or proof of legal guardianship. Print full legal name.

Name ________________________SS # ________________DOB: ________Relation________
Name ________________________SS # ________________DOB: ________Relation________
Name ________________________SS # ________________DOB: ________Relation________
Name________________________ SS # ________________DOB: ________Relation________

Adding New Spouse – Please add my new spouse to my insurance. Attach is a copy of the marriage certificate. Print full legal name.
Name ________________________SS # ________________DOB ______________

Dropping Spouse Due to Divorce – Please drop my ex-spouse from my insurance. Attached is a copy of the divorce decree. Print full legal name.
Name ________________________SS# ____________________DOB ____________
Mailing address of spouse required: ____

Adding or Dropping Dependent Children - The following dependent children should be (check appropriate action) ____added or _____dropped from my insurance. (If birth need copy of birth certificate or social security card)
Name ____________________________SS# ____________________DOB _______
Name ____________________________SS# ____________________DOB _______
Name ____________________________SS# ____________________DOB _______

I certify that all of my dependent children covered under the City's plan are below age 26. I also certify that these dependents do not have insurance through their employer. **I understand that I have an obligation to notify the city if a dependent child enrolls in or becomes eligible for his/her employer's insurance plan.**

Employee Signature: ________________________________ Date: ______________

Witness: ____ Date: ______________

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