

City and County of Denver 2009 Benefits Elections Form for Half Time Employees

This is your 2009 benefit election form.

1. If you are a new hire, you must complete this form and submit within 30 days of your hire date. Forms received after this date, will not be accepted.
2. If you experienced a life event, you must complete this form and submit within 30 days of the life event. The following are valid life events and the required documentation for each:

- Birth/Adoption – No documentation required. A copy of the birth certificate should be submitted as soon as obtained, but does not have to accompany the enrollment form.
- Divorce – a copy of the divorce decree
- Marriage – a copy of the marriage certificate
- Gain/loss of Coverage – Proof of gain/loss of other coverage with effective date.

Spousal Equivalent Enrollment: If you wish to elect coverage for a same-sex partner, please contact the CSA Benefits Unit for the appropriate forms.

Please submit completed forms to:

CSA Benefits Unit
201 W. Colfax, Dept 412
Denver, CO 80202
or fax to 720-913-5548 or E-mail to benefits@denvergov.org.

Please keep a copy of this form for your records.

Employee Information			
Name:			
Address:			
Date of Birth:		Employee ID:	
Hire/Life Event Date:		Department:	

Dependent Information - Please complete **ALL** boxes for each dependent. In order to claim a dependent under medical, dental, or vision they must be: your **CHILD, STEPCHILD OR SPOUSE** and be financially dependent upon you. If a dependent is listed that does not meet this criteria, you may be responsible for reimbursing the insurance carrier for all claims and re-paying the City for it's premium contribution for up to 12 months. Please note that social security numbers for each dependent enrolled are required to comply with the Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Payer program.

Dependent(s) Name	Medical	Dental	Vision	Relationship	Date of Birth	Social Security Number	Sex (Circle One)
							M F
							M F
							M F
							M F
							M F

TO MAKE CHANGES, CIRCLE THE DESIRED OPTION FOR EACH BENEFIT PLAN

Medical Options - Deductions listed below are taken the first two pay periods of each month.				
	Employee Only	Employee w/Children	Employee w/Spouse	Employee w/Family
Kaiser	\$116.28 (A1)	\$242.68 (A4)	\$272.50 (A2)	\$404.46 (A3)
Denver Medical Care Plan A	\$125.95 (B1)	\$212.43 (B4)	\$279.63 (B2)	\$395.65 (B3)
Aetna HMO (CSA)	\$164.62 (E1)	\$343.57 (E4)	\$385.79 (E2)	\$572.61 (E3)
Aetna POS (CSA)	\$109.61 (F1)	\$228.75 (F4)	\$256.86 (F2)	\$381.24 (F3)
Waive	\$0.00 (W)			

Dental Options - Deductions listed below are taken the first two pay periods of each month.				
	Employee Only	Employee w/Children	Employee w/Spouse	Employee w/Family
Delta EPO Group #6791	\$5.35 (A1)	\$11.22 (A4)	\$12.33 (A2)	\$18.74 (A3)
Delta DPO Low Group #6026	\$8.90 (C1)	\$18.08 (C4)	\$20.21 (C2)	\$34.59 (C3)
Delta DPO High Group #6793	\$12.83 (B1)	\$26.48 (B4)	\$29.16 (B2)	\$49.02 (E3)
Waive	\$0.00 (W)			

Vision Options - Deductions listed below are taken the first pay period of each month.				
	Employee Only	Employee w/Children	Employee w/Spouse	Employee w/Family
Superior Vision	\$6.38 (A1)	\$10.30 (A4)	\$13.68 (A2)	\$18.78 (A3)
Waive	\$0.00 (W)			

Short Term Disability Options - Deductions listed below are taken the first pay period of each month.	
Plan	Cost
70% of earnings to a \$350 max weekly benefit, 7 day wait	\$18.90 (A)
70% of earnings to a \$1500 max weekly benefit, 7 day wait	\$.0087xGross Monthly Earnings=Monthly Premium (B)
70% of earnings to a \$1500 max weekly benefit, 14 day wait	\$.0070xGross Monthly Earnings=Monthly Premium (C)
70% of earnings to a \$1500 max weekly benefit, 30 day wait	\$.0053xGross Monthly Earnings=Monthly Premium (D)
70% of earnings to a \$1500 max weekly benefit, 60 day wait	\$.0035xGross Monthly Earnings=Monthly Premium (E)
Waive	\$0.00 (W)

Medical Flex Cash - FSA Medical deductions are taken the first two pay periods of each month. Enrollment is required every year.	
Minimum Annual Contribution: \$120.00	
Maximum Annual Contribution: \$7500.00	
Flex Cash Medical (A)	Annual Pledge \$
Waive (W)	

Dependent Care Flex Cash - FSA Dependent Care deductions are taken the first two pay periods of each month. Enrollment is required every year.	
Minimum Annual Contribution: \$120.00	
Maximum Annual Contribution: \$5000.00	
Flex Cash Child DayCare (A)	Annual Pledge \$
Waive (W)	

Qualified Parking Flex Cash - Qualified Parking deductions are taken the first pay period of each month.	
Minimum Annual Contribution: \$60.00	
Maximum Annual Contribution: \$2460.00	
Qualified Parking Plan (A)	Annual Pledge \$
Waive (W)	

Prepaid Legal - Prepaid legal deductions are taken the second pay period of each month. Deductions are taken after tax.	
Hyatt Prepaid Legal (A)	\$15.75
Waive (W)	\$0.00

If you are enrolled in one or both of the Flex Cash plans, you agree to the following by signing this form:

I understand that any amounts remaining in my account(s) not used for eligible expenses will be forfeited in accordance with federal tax law. I further understand that the Flex Cash deductions will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of my/spouse's employment. I further understand that I may only be reimbursed for child care expenses related to children under age 13. The deadline to submit receipts for reimbursement for 2009 flexible spending accounts is March 31, 2010.

If you are enrolled in Hyatt Prepaid Legal, you agree to the following by signing this form:

I understand that my election will remain in effect until I submit a completed cancellation request or I am no longer an eligible employee or I terminate employment with the City. I understand that I may only submit a cancellation request form during the open enrollment period. I authorize the City to take the appropriate \$15.75/per month after-tax payroll deductions needed to maintain this election.

AUTHORIZATION:

All enrollees: I certify the above information to be correct to the best of my knowledge, and those individuals listed as "DEPENDENT" either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that it is my responsibility to report any change in the eligibility of my dependents; that the benefits and services of the elected plan are coordinated with those provided by any other group hospital or medical benefit or service plan; and that any controversy (including any claim for money damages) between any HMO Plan member or the member's heirs or personal representatives and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration instead of a court trial. By signing this enrollment form, I authorize the selected health benefit plan to use and access my medical records for claims processing, quality assurance and utilization of review purposes. This authorization will be valid for the duration of my enrollment in the selected health benefit plan.

Print Name: _____

Emplid: _____

Signature: _____
(Required for Enrollment)

Date: ____/____/____

Important Notice from The City and County of Denver About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City and County of Denver (The City) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City has determined that the prescription drug coverage offered by the Denver Health Medical Plan, Kaiser Permanente and Aetna are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City coverage will not be affected, your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current City coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you lose your current coverage with The City and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the entity listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 13, 2008

Name of Entity/Sender: Career Service Authority, City and County of Denver

Address: 201 W. Colfax, Dept 412, Denver, CO 80202

Phone Number: (720) 913-5697