2022/2023 OPEN ENROLLMENT FORM

EFFECTIVE AUGUST 1, 2022

To change your current health coverage, you must complete this form and upload it to Benefits by July 15, 2022. If not, your current medical, dental and vision coverage will remain the same for the 22/23 plan year.

Your Name ____ Social Security#__________________________

Address ____ Date of Birth ____________________________

Daytime Phone _____________________________________ Email __________________________________

MEDICAL CHANGES effective August 1, 2022

To **change** your current medical plan, please check the appropriate box below. I hereby elect the following coverage for myself and eligible dependents:

❒ **AETNA HMO (offered in CA only)**

Check one only
- ❒ Employee only
- ❒ Employee plus one
- ❒ Family

IF YOU ENROLL IN THE AETNA HMO, YOU MUST ELECT A PRIMARY CARE DOCTOR
Provider Name_______________________
Provider ID#[1] _______________________
Dependent doctor if different ______________
([1]use **Provider Search** to find provider ID#)

❒ **AETNA POS (lower/traditional deductible PPO)**
- ❒ Employee only
- ❒ Employee plus one
- ❒ Family

❒ **AETNA BASIC PPO (high deductible PPO)**
- ❒ Employee only
- ❒ Employee plus one
- ❒ Family

❒ **WAIVE MEDICAL COVERAGE**
I do not want medical coverage effective 8/1/2022

DENTAL CHANGES effective August 1, 2022

To **change** your current dental plan, please check the appropriate box below. I hereby elect the following coverage for myself and applicable dependents:

❒ **AETNA DMO**

Check one only
- ❒ Employee only
- ❒ Employee plus one
- ❒ Family

IF YOU ENROLL IN THE AETNA DMO, YOU MUST ELECT A PRIMARY CARE DENTIST
Provider Name_______________________
Provider ID#[1] _______________________
Dependent dentist if different ____________
([1]use **Provider Search** to find provider ID#)

❒ **AETNA PPO**
- ❒ Employee only
- ❒ Employee plus one
- ❒ Family

❒ **WAIVE DENTAL COVERAGE**
I do not want dental coverage effective 8/1/2022

VISION COVERAGE effective August 1, 2022

❒ **I want vision coverage effective 8/1/2022**
❒ Employee ❒ Employee plus one ❒ Family

❒ **I don't want vision coverage effective 8/1/2022**

DEPENDENT COVERAGE INFORMATION effective August 1, 2022

Please list eligible dependents below (use reverse side to add more). Marriage & birth certificates for kids required unless previously sent.

Add/Delete
❒ ❒ ____
Dependent #1 Last Name, First | Date of Birth | Sex | Relationship | Social Security#

Add/Delete
❒ ❒ ____
Dependent #2 Last Name, First | Date of Birth | Sex | Relationship | Social Security#

EMPLOYEE AUTHORIZATION (required)

I hereby authorize the transactions indicated on this form, including payroll deductions, if any, on a pre-tax basis for the coverage I elect. I further state that I understand that the election(s) I make cannot be changed until the next Open Enrollment period or within 30 days of a qualified change in status or other circumstances as defined by the Internal Revenue Code. I state that all information furnished is true and complete to the best of my knowledge and I authorize the carrier or agent to obtain medical records and information from providers relating to me and my eligible dependents, to the extent required to provide administrative services in connection with the plans.

____
Signature Date

Upload this form along with additional documentation (if required) via

SECURE WEB LINK FOR EMPLOYEE FORMS

(https://tpbenefits.com/forms) **by 7/15/22**