2023/2024 OPEN ENROLLMENT FORM

**EFFECTIVE AUGUST 1, 2023**

To change your current health coverage, you must complete this form and upload it to Benefits by July 14, 2023. If not, your current medical, dental and vision coverage will remain the same for the 23/24 plan year.

Your Name

Address Daytime Phone

**MEDICAL CHANGES effective August 1, 2023**

Social Security#

Date of Birth Email

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)** |  | **AETNA POS (lower/traditional deductible PPO)** |
| Check one only | * Employee only
 |  | * Employee only
 |
| * Employee plus one
 |  | * Employee plus one
 |
| * Family
 |  | * Family
 |
| IF YOU ENROLL IN THE AETNA HMO, YOU MUST ELECT A PRIMARY CARE DOCTORProvider Name Provider ID#1 Dependent doctor if different (1use [**Provider Search**](https://tpbenefits.com/s/provider-search.pdf)to find provider ID#) |  | **AETNA BASIC PPO (high deductible PPO)*** Employee only
* Employee plus one
* Family
 |
| * **WAIVE MEDICAL COVERAGE**

**I do not want medical coverage effective 8/1/2023** |

 **DENTAL CHANGES effective August 1, 2023** 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**  **AETNA PPO**

Check one

* Employee only  Employee only
* Employee plus one  Employee plus one

only

IF YOU ENROLL IN THE AETNA DMO, YOU MUST ELECT A PRIMARY CARE DENTIST

Provider Name Provider ID#1

Dependent dentist if different

(1use [**Provider Search**](https://tpbenefits.com/s/provider-search.pdf)to find provider ID#)

* Family
	+ Family
* **WAIVE DENTAL COVERAGE**

**I do not want dental coverage effective 8/1/2023**

 **VISION COVERAGE effective August 1, 2023**

* **I want vision coverage effective 8/1/2023**
	+ Employee  Employee plus one  Family
* **I don’t want vision coverage effective 8/1/2023**

 **DEPENDENT COVERAGE INFORMATION effective August 1, 2023**

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.

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

[**SECURE WEB LINK FOR EMPLOYEE**](https://wbproductions.app.box.com/upload-widget/preview?folderID=26011406909&title=EMPLOYEE%20FORMS&isDescriptionFieldShown=1&isEmailRequired=1&width=385&height=420&token=am0cwvmm1rl6qba9w8sfusjrkmu3ir1c)[**FORMS**](https://wbproductions.app.box.com/upload-widget/preview?folderID=26011406909&title=EMPLOYEE%20FORMS&isDescriptionFieldShown=1&isEmailRequired=1&width=385&height=420&token=am0cwvmm1rl6qba9w8sfusjrkmu3ir1c)

**by 7/14/23**

Signature Date