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 _____ Social Security#_____

Address _____ Date of Birth _____

Daytime Phone _____ Email _____

MEDICAL CHANGES effective August 1, 2023

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 8/1/2023

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**

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 8/1/2023

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.

_____ _____
Signature Date

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

SECURE WEB LINK FOR EMPLOYEE FORMS

by 7/14/23