2020/2021 OPEN ENROLLMENT FORM
EFFECTIVE AUGUST 1, 2020

To change your current health coverage, you must complete this form and return it to Benefits by July 17, 2020. If not, your current medical, dental and vision coverage will remain the same for the 2020/2021 plan year.

Your Name _____ Social Security#_____

Address _____

_____ Date of Birth _____

Daytime Phone _____ Email _____

MEDICAL CHANGES effective August 1, 2020

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

❒ **AETNA BASIC PPO (high deductible PPO)**

Check only one
- ❒ Self Only
- ❒ Self plus one eligible dependent
- ❒ Self plus two or more eligible dependents

❒ **WAIVE MEDICAL COVERAGE**
I do not want medical coverage effective 8/1/2020

DENTAL CHANGES AND VISION COVERAGE effective August 1, 2020

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 only one
- ❒ Self Only
- ❒ Self plus one eligible dependent
- ❒ Self plus two or more eligible dependents

IF YOU ENROLL IN THE AETNA DMO, YOU MUST ELECT A PRIMARY CARE DENTIST
Provider Name_____
Provider ID#[1] _____
Current dentist Y / N
Dependent dentist if different _____
([1]use Provider Search to find provider ID#)

❒ **AETNA PPO**
- ❒ Self Only
- ❒ Self plus one eligible dependent
- ❒ Self plus two or more eligible dependents

❒ **WAIVE DENTAL COVERAGE**
I do not want dental coverage effective 8/1/2020

VISION COVERAGE
- ❒ **I want vision coverage effective 8/1/2020**
- ❒ **I don't want vision coverage effective 8/1/2020**

DEPENDENT COVERAGE INFORMATION effective August 1, 2020

Please list eligible dependents below (use reverse to add more dependents). 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#

Add/Delete ❒ ❒ _____
Dependent #3 - 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

posted on benefits website by 7/17/20