mesa·az

BENEFIT ENROLLMENT/CHANGE FORM

Employer Section Information

☐ New Hire ☐ Qualifying Event: _____	☐ Adding Dependent(s) ☐ Dropping Dependent(s) ☐ Adding Coverage ☐ Dropping Coverage	☐ Full Time ☐ Part Time ☐ Retiree	Benefits Effective Date: _____

Member Information

Last Name:	First Name: MI:		Employee ID#:
Street:	City, State, Zip Code:		Date of Birth:
Home Phone #:	Work Phone #:	Gender: ☐ Male ☐ Female	SSN #:

Marital Status: ☐ Single ☐ Married

Medical/Prescription Drug Coverage Election (Choose One)

Plan Election: ☐ Basic Medical Plan (50/50) ☐ Choice Medical Plan (80/20) ☐ Copay Medical Plan (copay) ☐ Opt Out

Coverage: ☐ Member Only ☐ Member & Family

Dental Coverage Election (Choose One)

Plan Election: ☐ Preventive Choice (80/20) Max $1,000 ☐ Dental Choice (80/20) Max $2,000 ☐ Dental Choice Plus (80/20) Max $2,300 & Ortho ☐ Opt Out

Coverage: ☐ Member Only ☐ Member & Family

Vision Coverage Election (Choose One)

Plan Election: ☐ Basic Vision (12/24/24) ☐ Vision Plus (12/12/12) ☐ Premium Plus (12/12/12) ☐ Opt Out

Coverage: ☐ Member Only ☐ Member & Family

Supplemental Life Insurance Coverage Election

(Choose one)
☐ Enroll
☐ Decline

Coverage Election:
☐ Employee
☐ Spouse/Committed Partner
☐ Dependent Child(ren)

Coverage Amount:
Employee ☐ Amount: $___
Spouse/CP ☐ Amount: $_____
Child(ren) ☐ Amount: $_____

Voluntary Short-Term Disability

(Choose one)
☐ Enroll
☐ Decline

Plan Election:
☐ 14 Day Elimination Period
☐ 29 Day Elimination Period
☐ 44 Day Elimination Period

Flexible Spending Account Coverage Election

(Choose one)
☐ Enroll
☐ Decline

Coverage Election ($100 minimum required):
Medical reimbursement account for $_____per plan year (plan limit is $2,850 per year).
Medical expenses for employee and eligible dependents.

Dependent Care reimbursement account for $_____per plan year (plan limit is $5,000 per year).
Child care/ Day care expenses for eligible dependents (NOT for dependent medical expenses).

Dependent Information

Relationship	Gender	Last	First	MI	DOB (MM/DD/YYYY)	SSN
Spouse/CP	☐ M ☐ F					
Child □ Nat □ Step	☐ M ☐ F					
Child □ Nat □ Step	☐ M ☐ F					
Child □ Nat □ Step	☐ M ☐ F					
Child □ Nat □ Step	☐ M ☐ F					

Agreement and Signature

DOCUMENTATION IS REQUIRED IN ORDER FOR COVERAGE TO BE ACTIVATE OR DEACTIVATED (qualifying events must be submitted within 31 days):
Spouse: Marriage Certificate; All Children: Birth Certificate(s). **Stepchildren, Adoption, Legal, Foster**: Divorce Decree indicating parental responsibility for insurance or adoption/legal guardian/foster paperwork. **Newborns**: Proof of birth from the hospital.

Signature: Date:

For Office Use Only

Processed By:_____Date: _____

Notes: _____

□ HRM □ Letter 08/23/2022