BENEFIT ENROLLMENT/CHANGE FORM

You have 30 days from your date of hire or from the "Date of Event" listed under the "Reason for Enrollment or Change" section to complete and submit this form, and your responses below will be recorded as your election until the next Open Enrollment period. You will not be able to make changes to your enrollment elections unless you have a qualifying life event.

Section 1 Employee Information				Marital Status: ☐ Single ☐ Married ☐ Domestic Partner	Gender: ☐ Male ☐ Female	Date of Birth: MM / DD / YYYY
Last Name	First Name		MI		Former (if any)	Social Security Number
Street Address	City	State	Zip Code		Phone Number	Email Address

Section 2 Reason For Enrollment or Change	☐ New Hire	☐ Qualifying Life Event: _____	Date of Event: MM / DD / YYYY

Section 3 Medical Plan Selection	☐ CDPHP HMO w/ CarelonRx	☐ Anthem BC PPO w/ CarelonRx	☐ I Decline Coverage
Please choose one of the following:	☐ Employee Only	☐ Family	

Section 4 Dental Plan Selection	☐ Delta Dental PPO+ Premier	☐ Delta Dental DHMO (Blue Collar Only)	☐ CSEA EBF (Buildings & Code Only)	☐ I Decline Coverage
Please choose one of the following:	☐ Employee Only	☐ Family		

Section 5 Vision Plan Selection	☐ Davis Vision	☐ CSEA RBC Gold 12 (Buildings & Code Only)	☐ I Decline Coverage
Please choose one of the following:	☐ Employee Only	☐ Family	

Section 6 Dependent Information — Please complete in full – List additional dependents on separate sheet

Add	Delete	Last Name	First Name	MI	Gender	Social Security Number	Date of Birth	Relationship	Type of Coverage
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision

Section 7 Employee Signature	
By signing below, I hereby certify that all the information provided by me on this form is true and correct, and that I accept and agree to abide by the conditions described in the enrollment materials, benefit summaries, and/or health insurance plan documents for the health insurance I have selected. I also authorize the City to deduct from my wages the employee contributory share of the relevant health insurance premium. If the City cannot deduct the entire employee contributory share from my wages, I understand that I am responsible for promptly providing payment of the contributory share (or balance) to the City and that the City may terminate my health insurance coverage if I fail to do so. Regardless of whether I am then enrolled in City-sponsored health insurance or not, I also authorize the City to recoup any outstanding health insurance premiums from my future wages and/or any leave accrual buyout I receive when I leave City of Albany employment. I understand that the City will notify me in writing when it does so. By signing this form, I also attest that (a) I understand the dependent eligibility criteria, (b) the dependent information I am submitting is true and accurate, and (c) the dependents I am enrolling are eligible for health insurance coverage. I also hereby confirm that I understand and acknowledge that providing false information—or omitting relevant information—on this form may result in the denial of claims, immediate or retroactive cancellation of coverage, and/or the City of Albany taking action to recover funds spent due to my fraud and/or or fiscal misconduct. I also understand that it is my responsibility and duty to promptly notify the City of Albany Human Resources Office of any changes to the information provided by me on this form, including changes to the eligibility status of my dependents (HR@AlbanyNY.gov or 518-434-5049).	
Signature	Date

INSURANCE PRE-TAX/POST-TAX DEDUCTION

Your contribution towards your insurance (health, dental and/or vision) may be deducted in one of two ways: pre-tax or post-tax.

Post-tax means that you pay for your health insurance premiums from the wages/salary left over after Federal, State and Social Security taxes have been paid. **Pre-tax** means you pay for your health insurance premiums before the City calculates the taxes owed according to your income. By electing your insurance deductions on a pre-tax basis, you would pay less in taxes and therefore increase your net pay. If you earn $18,000 a year, and your contributory share is $100/month, you would save almost $30 a month in taxes by paying the premium on a pre-tax basis. Please note, however, a disadvantage of paying premiums pre-tax is that your Social Security benefits may be reduced by a small amount.

I have read and understood the above information and I wish to have my insurance premiums deducted as follows:

Health Insurance: ☐ Pre-Tax or ☐ Post-Tax ▪ Dental Insurance: ☐ Pre-Tax or ☐ Post-Tax ▪ Vision Insurance: ☐ Pre-Tax or ☐ Post-Tax

Signature _____ Print Name _____ Date _____

This Deduction Remains In Effect Until You Elect To Change It, Which May Only Be Done During Open Enrollment.

Section 8 Additional Dependent Information		Please complete if necessary to list additional dependents.							
Add	Delete	Last Name	First Name	MI	Gender	Social Security Number	Date of Birth	Relationship	Type of Coverage
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision