

Instructions for Adding Dependents to Your Employee Benefits

To add a new dependent to your benefits coverage, you must complete the following:

- **Health Plan Enrollment/Change Form.** By completing this form you can make changes to your medical coverage, dental coverage, and flexible spending accounts. To add a dependent, you must provide copies of marriage and/or birth certificates.
- **Optional/Dependent Group Term Life Enrollment Form.** This form gives you the option to do the following:
 - If you already have optional insurance coverage and would like to add dependent life insurance, you can enroll on this form.
 - If you already have supplemental and dependent life insurance, you can update the dependent/beneficiary section to reflect who is covered under your dependent life insurance.
- **Beneficiary Designation Form.** Complete this form if you would like to update your beneficiaries for your basic life insurance or optional life insurance.

Fax completed forms to 612-673-2533 or mail completed forms to:

City of Minneapolis, Human Resources-Benefits
250 S 4th Street - 100
Minneapolis MN 55415-1339



CITY OF MINNEAPOLIS - HEALTH PLAN ENROLLMENT/CHANGE FORM
For changes not available through HRIS Employee Self Service due to documentation requirements.

Employee Name _____ Employee Payroll ID # _____ Effective Date _____
 Home Phone _____ Work Phone _____

Enrollment/Change Reason: Check one and see requirements below.

- _____ **Waive or change coverage due to enrollment in another group plan.**
 _____ **Enroll in City plans due to loss of group coverage under another plan.**
 _____ **Enroll dependent(s) newly eligible due to birth, adoption, legal custody, marriage, loss of other coverage, etc.**
 _____ **Remove dependent(s) no longer eligible due to marriage, divorce, etc. (provide explanation below).**

- If change is due to a gain or loss of coverage under a non-City group plan, attach a copy of proof of 'other' coverage or LOSS of coverage showing the date coverage either went into effect or was cancelled.
- To add a dependent, you must provide copies of marriage and/or birth certificate or court documents related to placement/adoption or custody. To add a grandchild you must provide a copy of a federal tax return listing the child as a dependent and a copy of current report card, school registration, doctor's bill, or day care statement showing your current address.
- If change is due to divorce, you must provide a copy of your divorce decree - first page, last page, other page(s) referring to health insurance.

CURRENT MEDICAL COVERAGE:

_____ WAIVE _____ Single _____ Family
 _____ Medica Elect (Standard or Wellness)
 _____ Medica Essential (Standard or Wellness)
 _____ Medica Choice (Standard or Wellness)

CHANGE MEDICAL COVERAGE TO:

_____ WAIVE _____ Single _____ Family
Complete only if enrolling mid-year
 _____ Medica Elect (Standard or Wellness)
 _____ Medica Essential (Standard or Wellness)
 _____ Medica Choice (Standard or Wellness)

CURRENT DENTAL COVERAGE:

_____ Single _____ Family

CHANGE DENTAL COVERAGE TO:

_____ Single _____ Family

FLEXIBLE SPENDING ACCOUNTS:

_____ Decrease _____ Increase (or enroll) Annual Health Care Flexible Spending \$ _____ New Annual Amount
 _____ Decrease _____ Increase (or enroll) Annual Dependent Care Spending \$ _____ New Annual Amount

DEPENDENTS: Complete the information in the chart below.

NAME	SEX	RELATION-SHIP	SSN -Required by Federal law for Spouse	DATE OF BIRTH	MEDICAL		DENTAL		PRIMARY CLINIC NUMBER* (11 digits)
					Enroll	Delete	Enroll	Delete	
		SPOUSE							

* **Primary care clinic elections for Elect and Essential networks:** All family members must choose a primary care clinic within either the Elect network or the Essential network. You cannot split family members between the two networks. If you elect Medica Elect or Medica Essential, you must enter the 11-digit clinic number in the space provided. Visit the CityTalk website at http://citytalk/benefits/medical_insurance to find network providers.

DELETING DEPENDENTS: Print name / address of deleted dependent(s) and explanation for removing dependent(s)

As an employee, eligible to participate in the City of Minneapolis Medical Plan, I hereby authorize the City of Minneapolis to deduct required pre-tax premiums for coverages elected above. Further, I understand that if I fail to complete a health care option change on a timely basis that I may not be eligible to apply for medical plan coverage until the next Open Enrollment period.

 Employee Signature _____ Date _____

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 City of Minneapolis, Human Resources-Benefits, Room 100 Public Service Center, 250 S 4th Street, Minneapolis MN 55415-1339**

Some of the requested information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit staff to verify eligibility and enroll you and your dependents in health plan(s) and allows the plan provider(s) the ability to establish an enrollment record for you and your dependents. You are not required to provide this information, however, failure to do so may result in ineligibility and non-enrollment. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through subpoena or pursuant to Federal and State law.

**CITY OF MINNEAPOLIS
OPTIONAL/DEPENDENT GROUP TERM LIFE ENROLLMENT FORM**

Upon Application Approval

Employee Name (Last, First, MI)

Employee ID

Effective Date

Listed below are the optional and dependent life insurance coverage options. Once the Benefits Department is notified by the insurance company of your approved application, the appropriate paycheck deduction changes will be made. When making your selection, note the number to the right of each choice (1) and write this number on the 'Option Code' line to the far right.

YOUR OPTIONS

City Optional Life

- CIGNA Group Ins. 1x Annual Salary B-Tax (1)
- CIGNA Group Ins. 2x Annual Salary B-Tax (2)
- CIGNA Group Ins. 3x Annual Salary B-Tax (3)
- CIGNA Group Ins. 4x Annual Salary B-Tax (4)
- CIGNA Group Ins. 5x Annual Salary B-Tax (5)
- CIGNA Group Ins. 1x Annual Salary A-Tax (6)
- CIGNA Group Ins. 2x Annual Salary A-Tax (7)
- CIGNA Group Ins. 3x Annual Salary A-Tax (8)
- CIGNA Group Ins. 4x Annual Salary A-Tax (9)
- CIGNA Group Ins. 5x Annual Salary A-Tax (10)
- Waive (W)

Option Selected

Option Code: _____

B-Tax=Pre-tax deductions
A-Tax=After-tax deductions

City Dependent Life

You must be enrolled in Optional Life in order to enroll in Dependent Life.

- CIGNA Group Ins. \$5,000 A-Tax \$1.60 (1)
- Waive \$0.00 (W)

Option Code: _____

City Dependent Life
DEPENDENT(S) TO BE COVERED

Verification of Non-Smoking Status

This certifies that I have not used tobacco during the past 12 consecutive months and claim the right to enroll for the coverage indicated above at the reduced non-smoker rate applicable to my age bracket.

Signature _____

Please fill in percent of benefit for primary and contingent beneficiaries. Beneficiaries are considered to be primary unless specified as contingent (CON). The contingent is entitled to the life insurance benefit only in the event the primary beneficiary(s) is deceased at the time of payment. The total of all primary percentages must equal 100% and the total of all contingent percentages must equal 100%.

Dependent/Beneficiary Info	%	%	%	%	%
DEPENDENT/BENEFICIARY NAME	BEN	CON	RELATIONSHIP	DOB	SEX

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By my signature below, I authorize the deductions necessary (pre-tax or after-tax as applicable) to ensure coverage under my plan choices as indicated above.

SIGNATURE: _____ DATE: _____

CITY OF MINNEAPOLIS - BENEFICIARY DESIGNATION

Beneficiary Designation for: (Please Print)

Employee Name [Last, First, Middle Initial]

Employee Department

Employee Payroll ID#

Please complete the following Beneficiary Designation for each type of Life Insurance Plan in which you are enrolled. This information is requested for your Benefit records.

Follow these instructions for completing Designations for each Plan in which you are enrolled.

- (Box 1) Fill in the name of each Beneficiary who would receive payment of your Life Insurance in the event of your death.
- (Box 2) State the relationship (spouse, child, brother, friend, etc.)
- (Box 3) Beneficiary's birthdate
- (Box 4) 'F' Female or 'M' Male
- (Box 5) Social Security Number
- (Box 6) Percentage of the benefit to be paid to each
- (Box 7) 'P' for Primary Receiver or 'C' for the Contingent receiver in the event the Primary Beneficiary is also deceased.

BASIC LIFE INSURANCE		2	3	4	5	6	7
1	BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SEX	SOCIAL SECURITY #	% OF AMOUNT	PRIMARY (P) or CONTINGENT (C)

OPTIONAL LIFE (if enrolled)		2	3	4	5	6	7
1	BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SEX	SOCIAL SECURITY #	% OF AMOUNT	PRIMARY (P) or CONTINGENT (C)

Employee Signature

Date

Return completed form to: Human Resources-Benefits, Room 100 Public Service Center, 250 S 4th Street, Minneapolis MN 55415-1339

Some of the information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit Staff and our death benefit provider to verify eligibility and to process the payment of a death benefit, in the event of your death, to those you designate to receive the benefit. You are not required to provide this information, however, failure to do so can result in death benefits being paid to your estate and can result in probate. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through a subpoena or pursuant to Federal and State law.