Insurance Enrollment/Change Form

☐ Open Enrollment		FOR OFFICE USE ONLY				EFFECTIVE DATES
NEW	CHANGE	NO CHANGE	CANCEL	WAIVER		
					Medical Coverage	
					Dental Coverage	
					Vision Coverage	
Time Keeper #:			Benefits Officer:			

Please print or type information on this form.

Section 1: EMPLOYEE INFORMATION

Name LAST	FIRST	MIDDLE INITIAL	EMPLOYEE NO.	PHONE EXT.

DEPARTMENT	EMPLOYEE HOME ADDRESS

Section 2: HEALTH INSURANCE ELECTION

My election for medical coverage is: ☐ New ☐ Change to ☐ Unchanged ☐ Cancel

If you selected ***New*** or ***Change To***, please provide name of health carrier.

☐ Employee ☐ Employee +1 ☐ Family

HEALTH CARRIER

☐ I choose to ***waive*** medical coverage because I am covered under another plan. (You must complete waiver below.)

STATEMENT OF HEALTH INSURANCE COVERAGE - WAIVER (Attach current proof of coverage)

The subscriber to the other plan is: Name: _____ Relationship: _____

The insurance company is: _____

I, therefore, authorize my exclusion from the City group health insurance plan and hereby relieve the City of Torrance of any liability as the result of this voluntary exclusion. Further, if I choose to discontinue the above noted insurance while still an employee of the City of Torrance, I agree to immediately obtain equivalent coverage or apply for inclusion in the City's group health insurance plan.

Employee Signature _____ Date _____

Section 3: DENTAL INSURANCE ELECTION

My election for dental coverage is: ☐ New ☐ Change to ☐ Unchanged ☐ Cancel

If you selected **New** or ***Change To***, please provide name of dental carrier/plan.

☐ Employee ☐ Employee +1 ☐ Family

DENTAL CARRIER

Section 4: VISION INSURANCE ELECTION

My election for vision coverage is: ☐ New ☐ Change to ☐ Unchanged ☐ Cancel

If you selected ***New*** or ***Change To***, please provide name of vision carrier.

☐ Employee ☐ Employee +1 ☐ Family

VISION CARRIER

Section 5: EMPLOYEE AUTHORIZATION

This Insurance Enrollment/Change Form shall remain in effect unless it is terminated or amended. I hereby acknowledge that I have been informed of the amount of my required contribution for each benefit that I have selected based upon a schedule that has been provided to me.

I further acknowledge that this Insurance Enrollment/Change Form is binding subject to my right to make changes according to the provisions of the PEMHCA health plan and current insurance policies and subject to any changes required to comply with Federal and State laws. I further understand that this Insurance Enrollment/Change Form is not a contract of employment. I understand that, if I do not elect health coverage for myself under one of the health care plans, I must have other coverage through another source, in such case, I agree to provide the City with proof of such coverage.

Employee Signature _____ Date _____

RETURN ALL COPIES TO HUMAN RESOURCES.

WHITE - Payroll **YELLOW - Human Resources** **PINK - Employee**