Group # H880141

Division#

If any information is incorrect, please mark through and change. Add additional pages as needed

This form must be completed and returned to HR, October 23, 2020 – November 16, 2020

Annual Open Enrollment
Coverage Period 01/01/2021 – 12/31/2021

Social Security #:	**Last Name:**	**First Name:**	**Middle Initial:**

Mailing Address:	**City:**	**State:**	**Zip Code:**

Email Address (required):

Gender: **Date of Birth**:	**Marital Status:**	**Employee Phone Numbers:**

Circle (A) Add, (T) Delete or (W) Waive	**DEPENDENT INFORMATION ONLY (Dependent children eligible to age 26) Last Name, First Name**	**Relationship** (i.e., spouse, natural child, stepchild, legal guardianship, etc.)	**Date of Birth**	**Gender M/F**	**Dependent Social Security Number**
A / T / W					
A / T / W					
A / T / W					
A / T/ W					
A / T / W					

1. Are your Dependent Child(ren) listed above your biological child, stepchild or adopted child? ☐ Yes ☐ No If no, please answer the questions A-D below for the child(ren) that do not meet the relationships stated above:
   a. Please list the child's name and your relationship with the child:_____
   b. Does this child live with you? ☐ Yes ☐ No
   c. Do you have legal guardianship or conservatorship for this child? ☐ Yes ☐ No
   d. Will you provide more than six months of support & claim this child on your Federal Income Tax Return this year? ☐ Yes ☐ No
2. Are you or your dependents covered or eligible under any other group health coverage? ☐ Yes ☐ No If yes, provide name and address of other insurance company, name of insured person(s), policy and group number: _____
   _____
3. Do you or any of your Dependents have Medicare? ☐ Yes ☐ No If yes, provide name of insured person: _____
   Effective date: _____ and Medicare number (from Medicare Card)_____
4. Do you require additional dependent ID cards (18 years or older)?
5. For any child name above, is there a court order for providing health coverage? If yes, please attach. ☐ Attached

Is Your Spouse an employee of Gunnison County? If yes, please provide Name Employee Number and Social Security

Name:		Employee Number:		Social Security Number:	

****Important if you are waiving medical coverage, complete below. If you are enrolling in medical coverage and/or Dental and Vision, continue to page 2. Other signatures are required on pages 3 & 4.**

WAIVER OF COVERAGE (HIPAA provision may impact your eligibility to re-enter your health plan)

Although I (and my eligible Dependents) have been given the opportunity to enroll in the Benefit Plan offered by my Employer, I decline to enroll:

☐ Self ☐ Dependent(s), listed by Name_____

☐ Have other coverage; Name of Plan_____ Type of Coverage ☐ Medical

☐ Do not choose to make contribution

☐Other_____

Signature of Employee:_____ **Date:**_____

FIRST NAME:	LAST NAME:

SELECT YOUR PLAN FOR 2021: you must select only one plan for you and your eligible dependents. Employee Premium rates listed are per payroll period and are deducted on a pre-tax basis for the following coverage period. Rates are the employees' responsibility.

TIERS	TRADITIONAL
SINGLE	☐ $185.22
EE+SPOUSE	☐ $555.67
EE+CHILD(REN)	☐ $518.63
FAMILY	☐ $889.08
☐ **Keep current plan** ☐ Waive coverage	

TIERS	HDHP
SINGLE	☐ $149.56
EE+SPOUSE	☐ $448.67
EE+CHILD(REN)	☐ $418.76
FAMILY	☐ $717.88
☐ **Keep current plan** ☐ Waive coverage	

TIERS	DENTAL
SINGLE	☐ $26.12
EE+1	☐ $52.23
FAMILY	☐ $78.34
☐ **Keep current plan** ☐ Waive coverage	

TIERS	VISION
SINGLE	☐ $4.56
EE+1	☐ $9.32
FAMILY	☐ $13.54
☐ **Keep current plan** ☐ Waive coverage	

Name of +1 Dependent Dental if enrolling:
Name of +1 Dependent Vision if enrolling:

- The High Deductible Plan offers you to enroll into a Health Savings Account (HSA).
- The Traditional and HDHP Plans offer you to enroll into a Flexible Savings Account (FSA).
- If you choose to Opt-Out of the health insurance, you still have the option to enroll into the FSA.
- If you choose to enroll in the HDHP and elect an FSA, the FSA will be a limited-purpose FSA that covers qualified out-of-pocket expenses for dental or vision care only.

On the next page you may elect to enroll into a Health savings Account or Flexible Spending Account to enhance your health Insurance Plan. (For more information on these benefits, please refer to the Summary Plan Description).

FIRST NAME:	LAST NAME:

HEALTH SAVINGS ACOUNT HSA

APPLIES ONLY IF YOU HAVE ENROLLED INTO THE HDHP

Health Savings Account	Annual Elections
	Annual maximum Contribution (includes both employee and employer contributions)
Employee	**$3,600**
Employee +1	**$7,200**
Employee + 2 or More	$7,200
To Calculate your annual election for 2021, select desired amount to contribute per pay period X 12 (pay periods) = $ Annual elections	
☐ Health Savings Account	$ x12 pay periods = $ Annual Election
☐ Health Savings Account Catch-up Contribution (Age 55 & Over) $1,000	$ x12 pay periods = $ Annual Election

It is your responsibility to monitor and maintain your Health Savings Account (funds are only available as deposited)

- Avoid penalties by using Health Savings Account monies to pay for qualified healthcare expenses only
- Retain records of all transactions for possible IRS auditing purposes.
- See IRS regulations for eligibility and participation in an HSA. treas.gov/offices/public-affairs/hsa

FLEXIBLE SPENDING ACCOUNT (FSA)

HDHP enrollees will be subject to a limited purpose FSA

Flexible Spending Account	Annual Elections
	Annual Maximum Contribution
Health Care Reimbursement Account	**$2,750**
Dependent Care Reimbursement Account	**$5,000**
To Calculate your annual election for 2021, select desired amount to contribute per pay period X 12 (pay periods) = $ Annual elections	
☐ Health Care Reimbursement Account	$ x12 pay periods = $ Annual Election
☐ Dependent Care Reimbursement Account	$ x12 pay periods = $ Annual Election

Funds deposited into my Health Care and /or Dependent Care Flexible Spending Account (s) will be available to pay for eligible expenses during the plan year. I understand I cannot change my contributions during the plan year unless I have a status change. The plan year begins January 1, 2021 and ends December 31, 2021. I have until March 31 of the following year to submit expenses incurred during the plan year. I understand that Internal Revenue Service rules require that I forfeit unused account balances. Please refer to the Flexible Spending Account Summary Plan Description for complete details.

Signature of Employee:_____ **Date:**_____

GUNNISON COUNTY
ENROLLMENT DISCLOSURE AGREEMENT
(Required by the Health Insurance Portability and Accountability Act of 1996 – HIPAA)

SPECIAL ENROLLMENT RIGHTS
It is my understanding that even if I am declining to enroll at this time, I (and my eligible Dependents) may have Special Enrollment rights in the event that:
1. I (and my eligible Dependents) lose eligibility for other coverage; and/or
2. I acquire New Dependents.

SPECIAL ENROLLMENT PERIOD – LOSS OF ELIGIBILITY FOR OTHER COVERAGE
In the event I am declining to enroll in the Health Plan offered by my Employer due to having other coverage, I (and my eligible Dependents) may be subject to a Special Enrollment Period if I notify my Employer within thirty-one (31) days after the loss of eligibility for other sources of coverage.

SPECIAL ENROLLMENT PERIOD – NEW DEPENDENTS
In the event I acquire a New Dependent due to marriage, birth of a baby or adoption/placement for adoption of a child, I (and my New Dependents) may be subject to a Special Enrollment Period if I notify my Employer within thirty-one (31) days after the date of marriage, date of birth or date of adoption/placement for adoption.

SPECIAL ENROLLMENT PERIOD – MEDICAID OR CHIP
In the event I am declining to enroll in the Health Plan offered by my Employer due to having other coverage through Medicaid or CHIP, I (and my eligible Dependents) may be subject to a Special Enrollment Period if I notify my Employer within sixty (60) days after the loss of Medicaid or CHIP coverage or eligibility for premium payment assistance under Medicaid or CHIP.

LATE ENROLLEE
It is my understanding that in the event I (and my eligible Dependents) wish to enroll in the Health Plan offered by my Employer after expiration of the Initial Enrollment Period, and that if I am not subject to a Special Enrollment or if I fail to enroll by the end of a Special Enrollment Period, I can only enroll as a Late Enrollee during an Open Enrollment Period.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
If you are receiving covered benefits for a mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998. The Act provides for:

- Reconstruction of the breast(s) on which a covered mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications related to all stages of covered mastectomy, including lymphedema.

All applicable benefit provisions still apply, including existing deductibles, copays and/or coinsurance.

Signature of Employee:_____ **Date:**_____