



Tompkins County

Employee Benefits Change Form

For HR Use Only:
 HI Enrollment Code: 000367-____ - ____
 Enrolled with Vendors Date: _____ Entered in HRIS Date: _____
 Signature: _____

➤ Part 1: Employee Information

Employee Name:	Employee ID #:	Reason for Change:
Street Address:	Hire Date:	<input type="checkbox"/> Open Enrollment
City/State/Zip:	Effective Date:	<input type="checkbox"/> New Hire
Email:	Phone:	<input type="checkbox"/> Qualifying Life Event

➤ Part 2: Health / Dental / Vision / FSA Options

Health Plan	Dental Plan	Vision Plan	Flex Spending	HEALTH ELIGIBILITY:
<input type="checkbox"/> Platinum <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> PPO <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Classic Blue <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> CANCEL/WAIVE	<input type="checkbox"/> Dutchess Dental <input type="checkbox"/> Sunrise Dental <input type="checkbox"/> BCBS High <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> BCBS Low <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> CANCEL/WAIVE	<input type="checkbox"/> Platinum Vision <input type="checkbox"/> CANCEL/WAIVE	<input type="checkbox"/> Healthcare FSA <input type="checkbox"/> Dep. Care FSA <input type="checkbox"/> CANCEL/WAIVE	The Platinum plan is the sole option for Blue Collar, White Collar/Mgmt/Conf/Elected Officials hired after 08/17/15 , Sheriff Assn. hired after 02/03/16 , and Corrections hired after 09/04/17 . DENTAL ELIGIBILITY: Dutchess Dental is available to all employees aside from Blue Collar, Sunrise Dental is only available to Blue Collar, and BCBS Dental is only available to Mgmt/Conf/Elected Officials.

➤ Part 3: Flexible Spending Account Election Amount(s) Full Year of Pay Periods = 26 (bi-weekly employees) /12 (monthly employees)

Account	Min. Election	Max. Election	Annual Election	# of Pay Periods	\$ per Period	Note on Healthcare FSA:
Healthcare FSA	\$10.00 per Pay Period	\$2,750.00 Annual				Funds may be used for eligible expenses for all tax dependents. Up to \$550 in unused funds will roll over yearly if you are still enrolled in a Healthcare FSA.
Dependent Care FSA	\$10.00 per Pay Period	\$5,000.00 Annual				This type of FSA is for day care expenses for dependents up to age 13.

➤ Part 4: Employee/Dependent Enrollment/Cancellation Information

Please select Spouse or DP (Domestic Partner) if applicable. In the Health, Dental, Vision, and FSA columns, select Y to enroll in coverage or N to cancel or waive coverage.

Participant	Name (Last, First)	Gender	DOB	SSN	Health	Dental	Vision	FSA
Employee					Y <input type="checkbox"/> N <input type="checkbox"/>			
Spouse <input type="checkbox"/> DP <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 1					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 2					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 3					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 4					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 5					Y <input type="checkbox"/> N <input type="checkbox"/>			

Employee Signature: _____ Date: _____

Excellus BCBS Release (Classic Blue, PPO, Platinum Health Insurance Plans; BCBS High/Low Dental Plans):

- I am applying to enroll myself and my eligible dependents, if any, under the medical contract.
 - In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
 - If this application is made on behalf of a minor, the responsible party must complete the application.
 - By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
 - I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
 - PREFERRED PROVIDER ORGANIZATION (PPO) - I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
 - I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release.**

CSEA Release (Dutchess and Sunrise Dental; Platinum Vision):

- Not all employers allow domestic partner coverage. For New York State Employees; before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from The NYS Department of Civil Service. For Local Government employees, the confirmation must come from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
 - When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional information which may include verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
 - In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
 - An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.
 - For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com.
- I certify that the information provided on my enrollment form is correct.**

Benetech Release (Health and Dependent Care Flexible Spending Accounts):

- I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year starting ___/___/___ and ending ___/___/___ Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:
- I cannot change or revoke this agreement during the above Plan Year, unless I have a change in my family status as set forth in the Summary Plan Description.
 - My pay will be reduced each pay period by the amount of my election(s) shown on page 1, continuing for each succeeding pay period until this agreement is amended or terminated.
 - The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my payroll reduction will automatically be adjusted to reflect that change.
 - My employer may change the amount of my reduction or otherwise modify this agreement, if it believes that the change is required to satisfy provisions of the Internal Revenue Code.
 - The amount of my compensation reduction will be credited to the appropriate reimbursement account for payment of eligible expenses incurred within the plan year.
 - Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive.
 - Upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.
 - If there is a remaining balance in my account(s) at the end of the Plan Year (i.e., after all eligible claims have been reimbursed), I may forfeit that excess amount, based on the provisions of the Plan as detailed in the Summary Plan Description.
- By my signature, I hereby certify that any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan.**

Dependent Eligibility Verification Requirements:

- > If you are enrolling a **Spouse** or **Domestic Partner**, you must attach a copy of your **Marriage Certificate**, **Certificate of Domestic Partnership**, or **Affidavit of Domestic Partnership** (contact HR for Affidavit).
- > If you are enrolling any **Dependent Children** (including step children, children of a domestic partner or any children over whom you have custody), you must attach copies of **birth certificate(s)** and copies of adoption paperwork or court order of custody (if applicable).