CITY OF FORT SMITH

2022 EMPLOYEE BENEFIT SELECTION FORM

(THIS FORM MUST BE COMPLETED, SIGNED & RETURNED TO HR EVEN IF YOU ARE WAIVING ALL COVERAGES)

EMPLOYEE DEMOGRAPHICS

Employee Name:		Department:	
Social Security Number:		Date of Birth:	
Phone Number:		Date of Hire:	
Street Address:		Gender:	
Apt/Unit Number:		Marital Status:	
City, State, Zip:			

DEPENDENT DEMOGRAPHICS

	Name	Date of Birth	Social Security Number	Gender
Spouse:				
Child:				
Child:				
Child:				
Child:				
Child:				

2022 BENEFIT ELECTIONS

Medical	HealthSCOPE				
Plan 1 – $2,000 Deductible		Plan 2 - $1,250 Deductible		Plan 3 - $500 Deductible	
Please check election below	✓	Please check election below	✓	Please check election below	✓
Employee Only:		Employee Only:		Employee Only:	
Employee & Spouse:		Employee & Spouse:		Employee & Spouse:	
Employee & Child(ren):		Employee & Child(ren):		Employee & Child(ren):	
Employee & Family:		Employee & Family:		Employee & Family:	
Waive:		Waive:		Waive:	

Dental	Delta Dental of AR	
Please check election below	✓	Cost Per Pay Period
Employee Only:		$ 4.53
Employee + 1 Dependent:		$ 9.06
Employee & Family:		$ 13.59
Waive:		WAIVED

Vision	Superior Vision	
Please check election below	✓	Cost Per Pay Period
Employee Only:		$ 0.79
Employee + 1 Dependent:		$ 1.54
Employee & Family:		$ 2.27
Waive:		WAIVED

Voluntary Life	Mutual of Omaha				
			Please check elections below	✓	
	Guarantee Issue	Maximum Benefit	Benefit Amount Elected		Cost Per Pay Period
Employee:	$250,000	10x Salary-Max $500,000	$		$
Dependent Voluntary Life					
Spouse:	$10,000		$10,000		
Child:	$10,000		$10,000		
Waive:	WAIVE ALL VOLUNTARY LIFE INSURANCE				WAIVED

Short-term Disability	Mutual of Omaha	
Please check election below	✓	Cost Per Pay Period
Elect Short-term Disability:		$
Waive Short-term Disability:		WAIVED

BENEFITS CONTINUED ON NEXT PAGE

While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this form and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about your form, please contact Human Resources.

Accident	SunLife Financial		
	Please check election below	✓	Cost Per Pay Period
	Employee Only:		$ 6.19
	Employee & Spouse:		$ 9.63
	Employee & Child(ren):		$ 9.14
	Employee & Family:		$ 17.22
	Waive:		WAIVED

Critical Illness	SunLife Financial		
	Please check elections below		
	Benefit Amount Elected	✓	Cost Per Pay Period
Employee:	☐ $10,000 ☐ $20,000		$
Spouse:	☐ $5,000 ☐ $10,000		$
Child:	☐ $5,000 ☐ $10,000		$
Waive:	WAIVE ALL		WAIVED

Flexible Spending Account		
FSA Type	2021 Annual Maximum	Employee Annual Election
Health Care Flex	$2,750	$
Dependent Care Flex	$5,000	$

EMPLOYER PAID BENEFITS
Your employer provides $100,000 in Life Insurance, and Long-term Disability at no cost to you.

By signing below, I agree to the elections herein for myself and/or my dependents for the plan year January 1, 2022, through December 31, 2022. I understand that this election is made on an annual basis and cannot be changed until the next open enrollment period as set forth by the rules and regulations of the IRS Section 125 Cafeteria Plan code unless I incur a qualified life change in family or employment status.
I understand that under PPACA (The Patient Protection & Affordable Care Act) waiving coverage in my employer sponsored medical plan for myself and/or my dependents may result in a tax penalty if I and/or my dependents do not have other health coverage.

Employee Signature Date

DESIGNATION OF BENEFICIARY

As a participant in the **GROUP LIFE INSURANCE PLAN** you will need to complete this form naming the beneficiary(ies) you wish to receive benefits payable in the event of your death.

Employee Name:			
I wish to designate the following individual(s) as primary beneficiary(ies):			
Name	**Date of Birth**	**Relationship**	**Share**
I also wish to designate the following individual(s) as secondary beneficiary(ies)			
Name	**Date of Birth**	**Relationship**	**Share**

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