



## City of Savannah Special / Life Event Enrollment Form

### Applicability

Special Enrollment applies to you and/or your Dependent(s) if you/they are eligible for coverage under the City's group health plan (the Plan), and qualify under one of the Special Enrollment conditions described below. If you qualify under one of these conditions, please complete this form as well as the Benefits Enrollment Form and submit to the City's Benefits Division within **30 days** of the Special Enrollment condition.

### Special Enrollment Conditions

As a participant in the flexible benefits plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in family status.

I understand that the change in my benefit election must be necessitated by and consistent with the change in family status and that the change must be acceptable under the Regulations issued by the Department of the Treasury.

### I certify that I have incurred the following change in family status:

Change in Status	Supporting Documents Needed	Effective Date of Coverage	Period to Enroll
<input type="checkbox"/> Marriage	Marriage license	1st day of the 1st calendar month that begins after the date on which the Plan received the completed enrollment form	Within 30 days after the event date
<input type="checkbox"/> Divorce	Divorce decree	Date the divorce is final according to court decree	Within 30 days after the event date
<input type="checkbox"/> Birth	Hospital discharge papers or Birth Certificate <u>AND</u> Social Security Number	Date of Birth	Within 30 days after the event date
<input type="checkbox"/> Adoption	Adoption decree	Date of Adoption	Within 30 days after the event date
<input type="checkbox"/> Death	Death certificate	Date of death	Within 30 days after the event date
<input type="checkbox"/> Reaches Limiting Age	No documents needed – dependent will be dropped and offered COBRA coverage	End of Month of date dependent reaches age 26	N/A
<input type="checkbox"/> Gain/Loss of coverage from change in employment	Letter from previous or current employer that indicates change in employment status	1st day of the 1st calendar month that begins after the date on which the Plan received the completed enrollment form	Within 30 days after the event date
<input type="checkbox"/> Court Order (child support,	Copy of judgment, decree or order	1st day of the 1st calendar month that begins after the date on which the Plan received the completed enrollment form	Within 30 days after the event date
<input type="checkbox"/> Gain/Loss of coverage from Medicaid or state program or healthcare exchange	Letter from Medicaid or state agency or healthcare exchange indicating the date coverage terminated or commenced	1st day of the 1st calendar month that begins after the date on which the Plan received the completed enrollment form	Within 60 days after the event date

Employee Name: \_\_\_\_\_

Employee Number: \_\_\_\_\_

Employee Address: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Other Coverage Information**

**As a new participant/dependent of the Plan, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.**

Please mark one of the following categories and provide the requested information if it applies.

Single       Widowed       Divorced

Married (Spouse's Name): \_\_\_\_\_ Birth Date: \_\_\_\_\_

Do you have any other coverage?       Yes       No      If yes, please provide name address and telephone number.

Do your dependent children (if any) have other coverage?       Yes       No      If yes, please provide name address and telephone number.

Does your spouse have other coverage?       Yes       No      If yes, please provide name address and telephone number.

**ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.**

I represent that all statements and answers made above are true, complete, and correct. They will be part of my application for coverage.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# City of Savannah Beneficiary Form

Name: Last	First	Employee ID	Department
Contact: Email	Phone Number	Position	Date

**\*IMPORTANT:** List at least one beneficiary for your Life Insurance. Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise. **If no changes are needed to this section, select here \_\_\_**

### BENEFICIARY – LIFE INSURANCE

Name	Relationship	SSN	Date of Birth	Percent	Designation
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

**\*IMPORTANT:** If you are legally married, your Pension beneficiary MUST be your spouse. **If no changes are needed to this section, select here \_\_\_**

### BENEFICIARY - PENSION

Name	Relationship	SSN	Date of Birth	Percent	Designation
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

### Agreement and Authorization

I certify all information on this form to be correct to the best of my knowledge. I understand that it is my responsibility to report any change in the eligibility of myself or my dependents. By signing this enrollment form, I authorize the selected benefit plans to use and access my records for claims processing, quality assurance and utilization of review purposes. This authorization will be valid for the duration of my enrollment in the select benefit plans.

Subject to the terms of my employer's plan, I require that any sum becoming due upon my death be payable to the beneficiary/ies designated above. I understand this designation will supersede all prior designations made by me under my employer's plan. If more than one beneficiary is designated, payment will be made in the percentages designated (*or in equal shares*) to the primary beneficiaries who survive the participant. If no primary beneficiary survives the participant, payment will be made in the percentages designated (*or in equal shares*) to the contingent beneficiaries who survive the participant. If a percentage is not designated, it will be assumed that you wish the value of your plan account to be split equally among all designated beneficiaries. If no beneficiary survives the participant, payment will be made pursuant to the terms of the plan.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Submit Completed Form to City of Savannah Human Resources Department/Benefits Division.**