SAVANNAH
Human Resources

Benefits Enrollment Form

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

Important Enrollment Information regarding Medical, Dental, Vision and Life Insurance Plans:

- If you are covered for benefits as an employee, you cannot be covered as a dependent.
- Eligible children can only be covered by one parent under the insurances plans if both parents are employees and/or retirees of the City.
- In consideration of the above provisions, are you currently the dependent of another City of Savannah employee?
  ☐**Yes** ☐**No** **If yes, provide employee's name:** ______________________________
- Is your spouse a City employee? ☐**Yes** ☐**No** **If yes, provide employee's name:** ______________________
- In order to enroll in benefits as a new hire, you must complete this form and return it to the Human Resources Department within 30 days of your hire date.

MEDICAL	
Medical Option (Check one)	**Medical Level of Coverage (Check one)**
☐ Health Plan Plus ☐ Health Plan Basic ☐ Waive Health Plan	☐ Employee Only ☐ Employee + 1 ☐ Employee + Family
VISION	
Vision Option (Check one)	**Vision Level of Coverage (Check one)**
☐ Vision Plan ☐ Waive Vision Plan	☐ Employee Only ☐ Employee + 1 ☐ Employee + Family
DENTAL	
Dental Option (Check one)	**Dental Level of Coverage (Check one)**
☐ Dental Plan Platinum ☐ Dental Plan High ☐ Dental Plan Low ☐ Waive Dental Plan	☐ Employee Only ☐ Employee + 1 ☐ Employee + Family

FLEXIBLE SPENDING

Flexible Spending Account – MEDICAL – Maximum annual election estimated to be $2,850 subject to IRS approval
☐ Waive ☐Elect Annual Contribution: $_______________
Flexible Spending Account – DEPENDENT CARE – Maximum annual election is estimated to be $5,000 subject to IRS approval
☐ Waive ☐Elect Annual Contribution: $_______________

OPTIONAL SUPPLEMENTAL LIFE INSURANCE		
Employee (Check one)	**Spouse (Check one)**	**Dependent Child (Check one)**
☐ 1x Annual Base Salary ☐ 2x Annual Base Salary ☐ 3x Annual Base Salary ☐ 4x Annual Base Salary ☐ 5x Annual Base Salary ☐ Waive For New Hires: An Evidence of Insurability Application is required for any amount above 1x Annual Base Salary	Minimum of $10,000 up to a maximum of $100,000. Elect in multiples of $10,000. ☐ Coverage Amount: $_________________ ☐ Waive For New Hires: An Evidence of Insurability Application is required for amounts above $30,000	Minimum of $5,000 up to a maximum of $20,000. Elect in multiples of $5,000. ☐ $ 5,000/child ☐ $10,000/child ☐ $15,000/child ☐ $20,000/child ☐ Waive

DEPENDENTS COVERED UNDER MEDICAL, VISION AND/OR DENTAL

Name	Relationship	SSN	Date of Birth	Coverage
				☐ Med ☐Vis ☐Den ☐Lf
				☐ Med ☐Vis ☐Den ☐Lf
				☐ Med ☐Vis ☐Den ☐Lf
				☐ Med ☐Vis ☐Den ☐Lf
				☐ Med ☐Vis ☐Den ☐Lf

Created: 1/21/2013
Last Revised: 12/1/2021

City of Savannah Beneficiary Form

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

***IMPORTANT: List beneficiaries 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.**

BENEFICIARY DESIGNATION – LIFE INSURANCE

Name	Relationship	SSN	Date of Birth	Percent	Designation
					☐ Primary ☐ Contingent
					☐ Primary ☐ Contingent
					☐ Primary ☐ Contingent
					☐ Primary ☐ Contingent

BENEFICIARY DESIGNATION – PENSION

IMPORTANT: If you are married, your Pension beneficiary MUST be your spouse. Please contact Human Resources for additional information.** ***If your beneficiary resides at a different address than you, please provide the address.

Name	Relationship	SSN	Date of Birth	Percent	Designation
					☐ Primary ☐ Contingent
					☐ Primary ☐ Contingent
					☐ Primary ☐ Contingent
					☐ Primary ☐ 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 supercede 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 none survive 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.

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Last Revised: 12/1/2021