Division # _____ **POLK COUNTY GOVERNMENT** New _____ Change _____

Effective Date: **2018 MEDICAL & LIFE/LTD** Reason for Change:

Medical _____ **ENROLLMENT/CHANGE FORM** _____

Life/ADD _____ _____

Dep. Life _____ _____

LTD _____ _____

Please Print Clearly

Name (Last, First, MI) Social Security #

Mailing Address (Street No./P.O. Box, City, State, Zip Code)

Date of Birth: _____ Home PH#: _____ Sex (M/F): _____ Marital Status: M_____ D_____ S_____

Date of Hire: _____ Division: _____ Job Title: _____ Work PH#: _____

Check one	Listed Family Members to be Covered (include last name if different)	Relationship	Sex	Date Of Birth (mm/dd/yr)	Lives with Employee Y or N	Student Y or N	Social Security Number	**AETNA Options**
☐ Enroll ☐ Cancel ☐ Change								☐ DECLINE COVERAGE ☐ OA SELECT ☐ HRA **Type of Coverage:** ☐ EMPLOYEE ONLY ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE & FAMILY
☐ Enroll ☐ Cancel ☐ Change								
☐ Enroll ☐ Cancel ☐ Change								
☐ Enroll ☐ Cancel ☐ Change								

NOTE: If more space is needed to list dependents, please use separate sheet and attach to enrollment form.

MARRIAGE CERTIFICATE IS REQUIRED IF COVERING YOUR SPOUSE UNDER MEDICAL. CHILDREN ARE ELIGIBLE FOR MEDICAL COVERAGE PER THIS ELECTION IF THEY ARE AGE 26 OR UNDER AND BIRTH CERTIFICATE (OR ADOPTION PAPERS) IS REQUIRED AS PROOF OF PARENTHOOD.

OTHER MEDICAL COVERAGE

Will you or any listed dependent have OTHER health insurance when this coverage is in effect? ☐ Yes ☐ No	Coverage type: ☐ Individual ☐ Group Policy ☐ Medicare/Medicaid		Names of Family Members with other Coverage:
Medicare Claim Number:	Part A Effective Date: / /	Part B Effective Date: / /	Is Medicare eligibility due to: ☐ Kidney Failure ☐ Disability ☐ Retired

Employee Life

Employee Life/AD&D
☐ BASIC Life - $10,000

Optional Life*
☐ DECLINE COVERAGE
☐ 1/2 Salary
☐ 1 x Salary
☐ 1 1/2 X Salary
☐ **2 X Salary**
☐ **2 1/2 X Salary**
☐ **3 X Salary**
☐ **3 1/2 X Salary**
☐ 4 X Salary
☐ 4 1/2 X Salary
☐ 5 X Salary

Open Enrollment ONLY
Increase by:
☐ 1/2 X Salary
☐ 1 X Salary

***Cost may change with change in salary**

Dependent Life

Optional Dependent Life*
☐ DECLINE COVERAGE

Spouse Only		Child(ren) Only		Spouse & Child
Spouse $25,000	☐	Child $12,500	☐	☐
Spouse $20,000	☐	Child $10,000	☐	☐
Spouse $15,000	☐	Child $ 7,500	☐	☐
Spouse $10,000	☐	Child $ 5,000	☐	☐
Spouse $ 5,000	☐	Child $ 2,500	☐	☐
Spouse $ 2,500	☐	Child $ 2,500	☐	☐

***Child less than 6 months of age has $100 max benefit.**
***Children age 19-25 must be full/part-time students.**

Long Term Disability

Long Term Disability
☐ CORE Plan
(180 day elimination)

☐ BUY-UP Plan
(90 day elimination)

☐ I am not now disabled and am performing all the duties of my occupation on a full time basis

***DEPENDENT LIFE NOTE: Spouse coverage amount cannot exceed 50% of approved Basic+Optional Life election. (Does not apply to Child Only elections; max benefit is available.) If covering both spouse and children, preset combinations as listed above will apply. (i.e. Spouse $25,000/Child $12,500)**

***DATE OF MARRIAGE:** _____ **(Required only when Spouse Life elected and spouse is not also enrolled under Medical.)**

LIFE INSURANCE BENEFICIARY DESIGNATION

Primary Beneficiary: Date of Birth: Relationship: % of Share % (must = 100%)

Contingent Beneficiary:

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

Intentional falsification, or making false statements, is a fraudulent act and is subject to disciplinary action, up to and including termination of employment. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my and/or my dependent's coverage. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a FELONY OF THE THIRD DEGREE. By signing this enrollment form, I herby certify that all the information provided is true and correct.

SIGNATURE (This form must be signed)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled or added to this application, I authorize any healthcare professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history of services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security number for purposes of identification. A photocopy of this authorization will be as the original.

Employee Signature: **X** _____ Date: _____