Link: 2020 Employee Benefits Book

GROUP INSURANCE APPLICATION
CITY OF SAINT PAUL
2020

Employee Name (Last, First, MI)		Sex	Date of Birth	Social Security #	Bargaining Unit
Street Address	City	State	Zip Code	Email Address	
Name of Department			Home Phone #	Work Phone #	
Spouse Name (if also employed by the City of Saint Paul)	Spouse's Department		Spouse's City ID #		

MEDICAL PLANS by MEDICA- Select Single or Family and the Type of Plan

Single	$2,500 PPO Choice	$2,500 Elect Plan	$2,500 Park Nicollet ACO	$2,500 Vantage Plus ACO	$35 Copay Choice Plan
Total Cost	$665.26	$619.18	$599.56	$599.56	$850.22
City Contribution	$652.44	$619.18	$599.56	$599.56	$398.88
Employee Cost	○ $12.82	○ $0	○ $0	○ $0	○ $451.34

Family	$2,500 PPO Choice	$2,500 Elect Plan	$2,500 Park Nicollet ACO	$2,500 Vantage Plus ACO	$35 Copay Choice Plan
Total Cost	$1,736.74	$1,617.10	$1,565.84	$1,565.84	$2,230.20
City Contribution	$1,530.64	$1,530.64	$1,530.64	$1,530.64	$ 748.22
Employee Cost	○ $206.10	○ $86.46	○ $35.20	○ $35.20	○ $1,481.98

ADD	CANCEL		
☐	☐	Employee Only	Effective Date _____
☐	☐	Dependent Only – complete dependent information below	Effective Date _____
☐	☐	Employee and Dependent – complete dependent information below	Effective Date _____

EMPLOYEE AND DEPENDENT INFORMATION FOR HEALTH INSURANCE

NAME	RELATIONSHIP	SEX	DATE OF BIRTH MONTH	DAY	YEAR	SOCIAL SECURITY#
	☐ Employee					
	☐ Spouse					
	○ Child ○ Step-Child ○ Grandchild					
	○ Child ○ Step-Child ○ Grandchild					
	○ Child ○ Step-Child ○ Grandchild					

PLEASE NOTE: All employees, except Non-Represented Management and Elected Officials, who elect the medical plans *(see above) with Deductible ($2,500) plan for 2019 are eligible to receive a City contribution into a VEBA/HRA account in the amount of $75/month for single coverage; $45/month for family coverage. You do not have to elect the VEBA/HRA. Enrollment is automatic. Part time employee's contribution amounts will be prorated.

DELTA DENTAL INSURANCE

	Preventive	Comprehensive 1	Comprehensive 2
Single	○ $0.00	○ $19.12	○ $22.36
Single+1	○ $0.00	○ $37.54	○ $43.98
Family	○ $0.00	○ $59.32	○ $109.88

ADD	CANCEL		
☐	☐	Single	Effective Date _____
☐	☐	Single + 1	Effective Date _____
☐	☐	Family	Effective Date _____

EMPLOYEE AND DEPENDENT INFORMATION FOR DENTAL INSURANCE

NAME	RELATIONSHIP	SEX	DATE OF BIRTH MO	DAY	YR	SOCIAL SECURITY#
	☐ Employee					
	☐ Spouse					
	○ Child ○ Step-Child ○ Grandchild					
	○ Child ○ Step-Child ○ Grandchild					
	○ Child ○ Step-Child ○ Grandchild					

OTHER INSURANCE OPTIONS

Annual Salary _____

ADD	CANCEL		PRESENT AMOUNT	INCREASE/DECREASE	GRAND TOTAL	EFFECTIVE DATE
○	○	Employee Additional Life Insurance	$ _____	$ _____	$ _____	_____
○	○	Spouse Life Insurance	$ _____	$ _____	$ _____	_____
○	○	Dependent Life Insurance	$ _____	$ _____	$ _____	_____
○	○	Short Term Disability	$ _____	$ _____	$ _____	_____
○	○	Long Term Disability	$ _____	$ _____	$ _____	_____
○	○	Employee Accidental Death Insurance	$ _____	$ _____	$ _____	_____
○	○	Spouse Accidental Death Insurance	$ _____	$ _____	$ _____	_____

*Complete **HEALTH QUESTIONNAIRE** when required.

Spouse Name (if changing spouse insurance) _____

Spouse Date of Birth _____

BENEFICIARY: EMPLOYEE LIFE AND OPTIONAL ACCIDENTAL DEATH

Employee life insurance coverage provided by Minnesota Life includes an accidental death benefit. The optional accidental death benefit coverage is provided by Standard Insurance Company. You may designate a beneficiary for either or both of these coverages online in Employee Self Service. In the absence of a beneficiary designation, both of these coverages provide for payment in the following order of priority: 1. Your surviving lawful wife or husband; 2. Your surviving children in equal shares; 3. Your surviving parents in equal shares; 4. The duly appointed legal representative of your estate.

FLEXIBLE SPENDING ACCOUNTS

☐ New Enrollment for Plan Year 2020 ☐ Change during Plan Year 2020

Reason for Change: _____

Effective Date: _____ Plan Administrator Approval: _____

HEALTH CARE EXPENSE REIMBURSEMENT ACCOUNT (Complete 1 or 2) The maximum contribution is $2,750/year.

1. I direct $_____/**YEAR** to my Health Care Expense Reimbursement Account.
2. I do not wish to establish a Health Care Expense Reimbursement Account: ☐

DEPENDENT CARE (DAYCARE) EXPENSE REIMBURSEMENT ACCOUNT (Complete 1 or 2) The maximum contribution is $5,000/year.

1. I direct $_____/**YEAR** to my Dependent Care (Daycare) Expense Reimbursement Account.
2. I do not wish to establish a Dependent Care Expense Reimbursement Account: ☐

TRANSPORTATION PLAN- PARKING EXPENSE REIMBURSEMENT ACCOUNT (Complete 1 or 2) The maximum contribution is $270/month.

1. I direct $_____/**MONTH** to my Parking Expense Reimbursement Account.
2. I do not wish to establish a Parking Expense Reimbursement Account: ☐

ACKNOWLEDGMENT

1. I hereby apply for (or request change in) coverage as indicated above, for which I am eligible.
2. I understand that some coverages require approval of my insurability before they become effective.
3. I authorize payroll deductions for my share of the premiums and/or pre-tax flexible spending accounts; including back charges.

SIGNATURE OF EMPLOYEE	DATE	APPLICATION INPUT & DATE (for Benefits use only)
X		