2025 Benefits Enrollment Form

Please print legibly

Fax your form to **303 289 3739** OR email to **benefits@c3gov.com**

Name _____ Last 4 of SSN _____ Employee # _____

Reason for Enrollment ◯ New Hire ◯ Open Enrollment ◯ Life Event *Type of Life Event* _____

Date _____ Effective Date of Coverage _____

2024 Benefit Options	Costs shown are semi-monthly

Medical *United Healthcare (UHC)*

		Employee Only	*Employee + Spouse*	*Employee + Child(ren)*	*Employee + Family*
EPO Choice	◯ Decline	◯ $65.69	◯ $134.67	◯ $131.38	◯ $189.84
HMO Navigate *Employee PCP #_____*		◯ $35.54	◯ $72.84	◯ $71.07	◯ $102.69
HSA Choice Plus		◯ $29.25	◯ $59.95	◯ $58.49	◯ $84.52

Dental *Delta*

		Employee Only	*Employee + Spouse*	*Employee + Child(ren)*	*Employee + Family*
Base PPO	◯ Decline	◯ $0.82	◯ $11.62	◯ $14.04	◯ $29.89
Premier PPO		◯ $5.78	◯ $22.55	◯ $26.60	◯ $51.80

Vision *Vision Service Provider (VSP)*

		Employee Only	*Employee + Spouse*	*Employee + Child(ren)*	*Employee + Family*
Vision	◯ Decline	◯ $5.91	◯ $9.46	◯ $9.65	◯ $15.56

Flexible Spending Accounts (FSA) *24HourFlex*

Healthcare FSA Enrollment Eligibility Only for EPO Choice and HMO Navigate plans

Healthcare FSA ◯ Decline ◯ Elect **Annual Election: $_____**

$150 calendar year minimum, $3300 maximum
Annual amount is divided into equal installments thru remaining plan year pay periods

Dependent Care FSA ◯ Decline ◯ Elect **Annual Election: $_____**

$150 calendar year minimum, $5,000 maximum ($2,500 if married filing separately)
Annual amount is divided into equal installments thru remaining plan year pay periods

Health Savings Account (HSA) *Optum Bank*

Enrollment Eligibility Only for HSA Choice Plus plan

Health Savings Account ◯ Decline ◯ Elect **Annual Election: $_____ OR Per Paycheck Election: $_____**

$4300 individual annual maximum, $8550 family annual maximum. Additional $1,000 if age 55 or older. Annual amount is divided into 26 (bi-weekly) installments

Dependent Information Must be a dependent as defined in the Benefits Enrollment Guide If enrolling more dependents than space below provides, attach an additional sheet					Select coverage for each dependent		
Spouse Add	Full Name ☐ Legal Spouse ☐ Common Law Spouse	Social Security # ___ – ___ – ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________
Dependent(s) Add	Full Name ☐ Check if disabled	Social Security # ___ – ___ – ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________
Add	Full Name ☐ Check if disabled	Social Security # ___ – ___ – ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________
Add	Full Name Check if disabled	Social Security # ___ – ___ – ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________
Add	Full Name Check if disabled	Social Security # ___ – ___ – ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________
Add	Full Name Check if disabled	Social Security # ___ – ___ – ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________
Add	Full Name Check if disabled	Social Security # ___ ___ ___	Date of Birth	Gender ☐ Male ☐ Female	Medical ☐	Dental ☐	Vision ☐ PCP #________

ENROLLMENT SIGNATURE - The information provided on this form is true and correct to the best of my knowledge. I understand that City of Commerce City may take monetary and disciplinary action (up to termination) against me if I enroll individuals as dependents that are not eligible and/or provide false information. I further acknowledge that I have read the information provided on the backside of this enrollment form.

SIGNATURE: **DATE:**

PROVISIONS

- I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.
- I authorize my cost of the coverage to be deducted pre-tax and allow this pre-tax deduction to carry-over to subsequent years. To elect post-tax payroll deduction, I understand it's my responsibility to contact the Human Resources Department and complete the appropriate paperwork.
- I authorize payment of any and all benefits payable under the policy to any licensed provider of care who treats me and/or my covered dependents.
- I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.
- I understand that the information contained in the Benefits Enrollment guide is high-level and if I want copies of the plan details I need to request them from the Human Resources Department or insurance provider.
- I have read and agree to the terms and conditions included with this enrollment form. Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in CRS-10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.
- It is unlawful to knowingly provide false, incomplete or misleading information to an insurance company to defraud or attempt to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civic damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding the policyholder or claimant with regard to their insurance benefits to the Colorado Division of Insurance.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

- By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, United Healthcare (medical), Delta (dental) and VSP (vision), does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an enrollment period, United Healthcare, Delta and VSP, does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code.