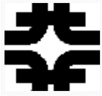

Fermilab

EMPLOYEE GROUP BENEFIT ACTION FORM

Return Form to: Benefits Office M.S. 126

ID: ☐ **LAST NAME:** ☐ **FIRST NAME:** ☐ **M.I.:** ☐

ADDRESS: ☐ **CITY:** ☐ **STATE:** ☐ **ZIPCODE:** ☐

DATE OF BIRTH: ☐ **SOCIAL SECURITY NUMBER:** ☐ **HOME PHONE NUMBER:** ☐

Select One: ☐ **New Employee** ☐ **Rehire** ☐ **Reinstatement** ☐ **Birth** ☐ **Adoption**

Select One: ☐ **Full-Time** ☐ **Part-Time**

Reason for Change: ☐ **Beneficiary** ☐ **Add Dependent** ☐ **Cancel Dependent** ☐ **Address** ☐ **Marriage**

☐ **Marital Status**__________________ ☐ **Other**_________________________

Office Use Only:

		Effective Date:	Time Reporting:
☐	Long-Term Disability Insurance	☐	☐ Exempt (Monthly)
☐	Sick Leave, Vacation, Floating Holiday	☐	☐ Non-Exempt (Weekly)

MEDICAL COVERAGE SELECT ONE:

- ☐ CIGNA Open Access Plus [FACT]
- ☐ CIGNA Network POS [FACT] - 100IL053
- ☐ Blue Advantage HMO [0000]
- ☐ Waive Coverage * [0000]
- ☐ CERN (Medical and Dental - CERN Assignees Only)

LEVEL OF COVERAGE:

- ☐ Employee Only
- ☐ Family

Effective Date (Office Use Only):

* I waive coverage because I and/or my dependents have medical coverage under another plan for which I am required to provide proof. I understand by waiving coverage that I can subsequently enroll only during the annual enrollment period or when I qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1996.

Initial Enrollment: List below yourself and all eligible dependent(s) you are enrolling in your plan. Adding Dependent(s) to Coverage: List below only the new dependent(s) you are adding to your plan.

Dropping Dependent(s) From Coverage: List below only the dependent(s) you are dropping from your coverage and write "cancel" next to their name(s).

Name: Last / First / M.I.	Social Security Number (If Available)	Sex	Date of Birth	Blue Advantage or Cigna POS Primary Care MD Name	Blue Advantage (3 digit medical group#) or Cigna POS MD#
Self:					
Spouse:					
Dependent 1:					
Dependent 2:					
Dependent 3:					

DENTAL COVERAGE SELECT ONE:

- ☐ CIGNA Dental PPO [FACT]
- ☐ CIGNA Dental Health (HMO) [FACT]
- ☐ WAIVE COVERAGE*
- ☐ CERN (Included With Medical)

LEVEL OF COVERAGE:

- ☐ Employee Only
- ☐ Family

Effective Date (Office Use Only):

* If you waive dental coverage for yourself or your dependents (including your spouse), you can only subsequently enroll at the next annual enrollment or when you qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1996.

Initial Enrollment: List below yourself and all eligible dependent(s) you are enrolling in your plan. Adding Dependent(s) to Coverage: List below only the new dependent(s) you are adding to your plan.

Dropping Dependent(s) From Coverage: List below only the dependent(s) you are dropping from your coverage and write "cancel" next to their name(s).

Name: Last / First / M.I.	Social Security Number (If Available)	Sex	Date of Birth	CIGNA Dental Health (HMO) Enter 6 Digit Dental Office#
Self:				
Spouse:				
Dependent 1:				
Dependent 2:				
Dependent 3:				

Last Name: ______________________________ First Name: ________________________________

CIGNA LIFE INSURANCE/AD&D OPTIONS:

EMPLOYEE COVERAGE:

- ☐ BASIC (Paid by Fermilab) - 1x Salary [BASIC]
- ☐ SUPPLEMENTAL I [SUPLF1]
- ☐ SUPPLEMENTAL II [SUPLF2]
- ☐ SUPPLEMENTAL III* [SUPLF3] EOI ☐ Yes ☐ No
- ☐ SUPPLEMENTAL IV* [SUPLF4] EOI ☐ Yes ☐ No

* Medical Evidence of Insurability required, contact Benefits Office for insurance application.

- ☐ AD&D (Paid by Fermilab) - Up to $12,500 Max. [AD&D 1-5]

DEPENDENT COVERAGE:

- ☐ OPTION A** (Spouse $5,000/Child(ren) $2,000) [DEP-A]
- ☐ OPTION B** (Spouse $10,000/Child(ren) $4,000) [DEP-B]

** Option A or Option B requires Supplemental Life Insurance enrollment

Effective Date (Office Use Only):

LIFE INSURANCE BENEFICIARY (Applies to all above coverages):

PRIMARY BENEFICIARY	Address (if different from yours)	Relationship	Sex	Date of Birth	% or Flat Amount

SECONDARY BENEFICIARY	Address (if different from yours)	Relationship	Sex	Date of Birth	% or Flat Amount

The above beneficiaries apply to all of the employee's coverages. The employee is the beneficiary of the dependent coverage. Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved to the insured.

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM:

I hereby authorize Fermilab to reduce my earnings for the current plan year for deposit into my Health and/or Dependent Care Reimbursement Account and to make this money available to me for the reimbursement of eligible out-of-pocket health expenses. **I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR FILING PERIOD. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.**

Health Care Annual Contribution Amount $_____________________(Maximum Contribution is $2,500)

Dependent Care Annual Contribution Amount $__________________(Maximum Contribution is $5,000)

Note: Salary reduction elections must be made in whole dollar amounts. These elections will be divided by the number of pay periods in the current plan year and be credited to your Account (s) on a monthly basis. Your salary reduction is made on a pre-tax basis in accordance with the IRS Section 125 guidelines.

Office Use Only

Health Care: Goal Amount $______________ Effective: ________________

Dependent Care: Goal Amount $______________ Effective: ________________

EMPLOYEE NOTIFICATION:

Single employees are eligible to select only one health plan. Married employees are eligible to select only one health plan for themselves and their dependents. (If both husband and wife are employees of the FRA/Fermilab, they cannot be covered under more than one health plan. Each can be in a separate plan, but each cannot be covered under two plans. Their eligible children are covered as dependents of only one parent.)

EMPLOYEE AUTHORIZATION AND CERTIFICATION:

I authorize Fermilab to deduct from my paycheck the appropriate contributions, if any, to the employee benefit plans that I have elected. Contributions for medical and dental coverage will be done on a before tax basis unless I sign a waiver form. I hereby certify that the information I have provided on this form is true and correct to the best of my knowledge.

EMPLOYEE SIGNATURE **DATE** **BENEFITS OFFICE** **DATE**