



**RETURN TO FINANCE DEPARTMENT NO LATER THAN MONDAY SEPTEMBER 21, 2015 AT 4:00 P.M. ALL FIELDS REQUIRED**

# City of Waupaca Health & Vision Plan Election Form Protective Services – No WRS Contribution

Full Name (please print) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security No.\* \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

**Indicate your decision for enrollment in the following insurance plans (Costs listed are per pay period):**

**Medical** plan (WCA Group Health Trust/UMR \$3,000/\$6,000 Deductible):

\_\_\_\_\_ Single (\$26.10) \_\_\_\_\_ Employee + 1 (\$52.25) \_\_\_\_\_ Family (\$73.20)

\_\_\_\_\_ Waive Medical Coverage

Reason for Waiving Medical Coverage \_\_\_\_\_

**Superior Vision** plan

\_\_\_\_\_ Single (\$3.96) \_\_\_\_\_ Ee/Spouse (\$7.92) \_\_\_\_\_ Ee/Child(ren) (\$8.93) \_\_\_\_\_ Family (\$13.82)

\_\_\_\_\_ Waive vision coverage

\*Dependent Information – Due to the Affordable Care Act, if you are electing medical, dental or vision coverage for your spouse and/or dependents we will need the following information:

<u>Full Name</u>	<u>Date of Birth</u>	<u>Social Security #**</u>	<u>Gender</u>	<u>Spouse/Child</u>	<u>Coverage(s)</u>
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision

I authorize the City of Waupaca to make payroll deductions for applicable premiums of the plan(s) for which I enrolled on a pre-tax basis:

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_