NAME_____

DEPARTMENT_____

EMPLOYEE NUMBER_____

BENEFIT ELECTION FORM

2021 Dental & Vision Plan Year

January 1, 2021 through December 31, 2021

Complete this form and **return it to Finance during your first two weeks of employment**.

SELECT OPTION 1: If you are enrolling or changing your current dental and/or vision elections; and **ATTACH YOUR DENTAL AND/OR VISION ENROLLMENT FORMS.**

SELECT OPTION 2: If you do not wish to elect dental or vision coverage.

_____ **Option 1** I choose to enroll in the Dental and/or Vision Plan(s) as circled below; and I understand that the premium(s) will be deducted from my salary on a pre-tax basis, thereby reducing the amount of Federal, State, and Social Security (FICA) taxes I pay.

(Note: Circle level of coverage for **one** of the dental plans and/or the vision plan you wish to enroll in – indicate your plan choice on your enrollment form)

DELTA DENTAL EPO

Level of Coverage: Employee Only Emp+Minor Family

DELTA DENTAL PPO PLUS PREMIER

Level of Coverage: Employee Only Emp+Minor Family

EYEMED VISION CARE

Level of Coverage: Employee Only Emp+Child(ren) Emp+Spouse Family

I also understand that:

- The only way the level of coverage (Employee, Employee+Minor, or Family) may be changed during the Plan Year is if I have a change in family status, which the IRS defines as: marriage, divorce, legal separation, birth/adoption/legal custody of a dependent child, death of a spouse or dependent child, loss of a dependent child's status, termination or commencement of a spouse's employment which affects coverage, change from part-time to full-time status (or vice versa) by the employee or the employee's spouse which affects coverage, or unpaid leave of absence taken by the employee or employee's spouse which affects coverage, **PROVIDED I NOTIFY THE DEPARTMENT OF FINANCE OF MY CHANGE IN FAMILY STATUS WITHIN 31 DAYS OF THE CHANGE;**
- Completion of this form will continue my enrollment in future plan years unless I fill out a new form not to participate (which can only be done at the end of each plan year for the next plan year);
- Calculations for the City of Hampton Deferred Compensation Plan and Social Security (FICA) will be on the reduced salary rather than the gross salary (therefore my future Social Security benefits may be affected by this choice since I will be paying less Social Security tax).

_____ **Option 2** I choose **NOT TO ENROLL** IN THE Dental and/or Vision plan(s) at this time. Once the initial waiting period is over, I understand that this is my only opportunity to enroll in either of them during this Plan Year but I will have an opportunity to enroll in future years.

Documentation is required to enroll family members. Attach copies of birth certificates, adoption papers, or court-ordered custody papers to cover dependent children and a marriage certificate to cover your spouse.

_____ _____

Employee's Signature Date