2021 OPEN ENROLLMENT VIRTUAL MEETINGS
MEDICAL, DENTAL, VISION, AFLAC SUPPLEMENTAL, AND VOLUNTARY LIFE INSURANCE

This year's open enrollment will be conducted via virtual online meetings using GoToMeetings. There are three simple ways to participate: 1) Click one of the links below based on the time you're interested in attending. You will be able to join by audio, or both audio and video, or 2) Copy and paste the chosen meeting link below into your web browser, or 3) Go to www.gotomeeting.com and join a meeting by entering the 9-digit meeting number (no dashes) found at the end of each link below. Not into technology, no problem….simply call Karin Graves, Employee Benefits Specialists at (954) 838-4528 or email kgraves@sunrisefl.gov for immediate assistance.

Open enrollment is the time of year when you are able to make changes to your employee group insurance benefits. These changes may be adding or deleting eligible dependents, discontinuing coverage, changing between plans, updating beneficiary forms, or electing new coverage for the first time. The effective date for coverage changes is January 1, 2021. There are no changes in rates or benefit levels this upcoming year for medical, dental, vision and voluntary life insurance. AFLAC supplemental coverages will remain the same for existing participants, but offer new plans and rates for newly elected coverage. Unless you are electing new coverage for the first time, or making changes to your existing coverage, your current benefits will continue uninterrupted and there is nothing you need to do.

1-HOUR VIRTUAL MEETINGS HELD DURING THE FOLLOWING TIMES:

Monday, October 19th at 10:00am
https://global.gotomeeting.com/join/505695877
Tuesday, October 20th at 9:00am
https://global.gotomeeting.comj/oin/383536453
Wednesday, October 21st at 8:00am
https://global.gotomeeting.com/join/216569045
Thursday, October 22nd at 3:00pm
https://global.gotomeeting.com/join/432721781
Friday, October 23rd at 10:00am
https://global.gotomeeting.com/join/987111629
Monday, October 26th at 1:00pm
https://global.gotomeeting.com/join/135798405
Tuesday, October 27th at 7:00am
https://global.gotomeeting.com/join/116529245
Wednesday, October 28th at 10:00am
https://global.gotomeeting.com/join/487119141
Thursday, October 29th at 8:00am
https://global.gotomeeting.com/join/648707893
Friday, October 30th at 10:00am
https://global.gotomeeting.com/join/911664685

Monday, October 19th at 2:00pm
https://global.gotomeeting.com/join/637054117
Tuesday, October 20th at 12:00pm
https://global.gotomeeting.com/join/411375533
Wednesday, October 21st at 1:00pm
https://global.gotomeeting.com/join/755984181
Thursday, October 22nd at 8:00pm
https://global.gotomeeting.com/join/151490949
Friday, October 23rd at 4:00pm
https://global.gotomeeting.com/join/390069397
Monday, October 26th at 6:00pm
https://global.gotomeeting.com/join/612096669
Tuesday, October 27th at 7:00pm
https://global.gotomeeting.com/join/406638965
Wednesday, October 28th at 7:00pm
https://global.gotomeeting.com/join/641275029
Thursday, October 29th at 12:00pm
https://global.gotomeeting.com/join/532204693
Friday, October 30th at 2:00pm
https://global.gotomeeting.com/join/948066821

Sessions are open to all eligible employees, dependents and retirees. Open Enrollment information is available on both CityConnect (City's intranet) under Risk Management/Benefits, and on the City's website (www.sunrisefl.gov) under Departments/Finance & Administrative Services/Risk Management. Enrollment forms will be accepted either via e-mail, interoffice mail, or regular mail to City of Sunrise, Risk Management Division, 10770 W. Oakland Park Blvd., 3rd Floor, Sunrise, FL 33351.

The deadline to submit your enrollment forms to Risk Management is November 13, 2020, by 5:00PM.

2021 MEDICAL, DENTAL & VISION MONTHLY RATES			
Plan Type	**2021 Retiree Only Premium**	**2021 Retiree + 1 (spouse) Premium**	**2021 Retiree Family Premium**
MEDICAL - HMO	$722.77	N/A	$1,860.43
MEDICAL - POS	$923.54	N/A	$2,377.13
Dental-DHMO	$16.89	$29.58	$46.47
Dental-PPO-Low $1,000	$29.77	$56.39	$88.32
Dental-PPO-High $2,000	$46.60	$88.26	$138.22
Vision	$6.60	N/A	$16.03

Rates remained unchanged from 2020

City of Sunrise Florida
Group Medical, Dental and Vision Plan

__New Enrollment __Reinstate
__Open Enrollment __Change

OFFICE USE ONLY Classification: **RETIREE**
Effective Date of Coverage:_____/_____/_____

Subscriber Information

Retiree Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F

Mailing Address	Apt.	City	State	Zip	Phone ( ) _____- _____

Last Department/Division	Last Job Title			Email:

If this is a Change, Indicate Type: __Add Dependent(s) __Drop Dependent(s) __Drop Employee and Dependent(s), if any
(attach document for proof) **Changes must be made within 31 days of qualifying event, as per IRS Sec 125 guidelines**

__New address(as above), __New Name: From_____ to _____

This Change is due to: ___Marriage ___Birth ___Separation of Employment ___Other:_____ Date of Event: _____

Additional Information

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date? __Yes __No Dental? __Yes __No

If yes, list Covered Person(s):_____

Insurance Company Name: _____ Do you or your spouse have Medicare? __Yes __No

Covered Individuals	**Medical-HMO**	**Medical-POS**	**Dental-HMO**	**Dental-HMO**	**Dental-PPO Low Option**	**Dental-PPO High Option**	**Vision**
Indicate your medical, dental and/or vision coverage options by placing an X in the appropriate ( )	**Indicate Option**	**Indicate Option**	**Indicate Option**	**Retiree Facility #**	**Indicate Option**	**Indicate Option**	**Indicate Option**
Single	( )	( )	( )		( )	( )	( )
Retiree and One Dependent*	**N/A**	**N/A**	( )	**N/A**	( )	( )	**N/A**
Family	( )	( )	( )	**N/A**	( )	( )	( )

*Eligible dependents are: spouse and/or natural, adopted or awarded child as defined in the plan document.

List below **all** eligible dependents you wish to cover on your medica,dental or vision plan. This enrollment form will replace all previously completed forms. Only those listed below will have coverage on the effective date of this enrollment or change.

Last Name First M.I.	**Date of Birth**	**Gender**	**Social Security Number***	**Coverage Selection**
(2)Spouse	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(3) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(4) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(5) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(6) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____

Proper documents required: marriage certificate, birth certificate, hospital birth record, adoption award, medical child support order.

Authorization

I hereby (1) **REQUEST** coverage for the Group Medical, Dental and/or Vision Plan for which I am, or may become eligible; (2) authorize the Pension Administrator to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. *The social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Retiree Signature _____ **Date**_____

Declination - complete this section only if declining or canceling your single coverage

I hereby **DECLINE** ___**Medical** ___**Dental** ___**Vision** coverage. I realize that once I cancel my single medical and/or dental coverage, I may not elect the canceled coverage in the future. Coverage must be continued from the time of retirement and, if canceled, cannot be reinstated.

Retiree Signature _____ **Date**_____

Reset

Standard Insurance Company **Beneficiary Designation/Change**

This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance, AD&D Insurance and, unless specified otherwise on a separate signed sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime. Return the completed form to your Risk Management Department.

MEMBER/EMPLOYEE INFORMATION

Your Name (Last, First, Middle)		Date of Birth
Your Address		
City	State	Zip
Group Name **City of Sunrise**	Group No. **755780**	

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%.

PRIMARY - Full Name	Address	Date of Birth	Relationship	% of Benefit

CONTINGENT - Full Name	Address	Date of Birth	Relationship	% of Benefit

Signature of Member/Employee

Date

Risk Management Department - *Retain for your records.*

Print (12/09)