



## 2021 Waukesha County Annual Open Enrollment Election Form

All regular full-time and regular part-time employees must submit an Open Enrollment Election form again for 2021 coverage. Completed election forms are due back to Human Resources by October 31, 2020. Due to a system upgrade in Employee Self Service, all 2021 elections must be completed on this form and will not be submitted via Self Service.

**PRINT CLEARLY**

**Employee Name** \_\_\_\_\_

**Street Address** \_\_\_\_\_

**City, State Zip** \_\_\_\_\_

Please refer to your 2021 Open Enrollment Guidebook for more information regarding plan design, costs, or contribution limits. Benefit information is also available on [www.waukeshacounty.gov/openenrollment](http://www.waukeshacounty.gov/openenrollment) or on the County Intranet Connection (HR > Benefits). You may review your existing benefit elections along with enrolled dependents in Self Service by logging into <https://selfservicewauk.waukeshacounty.gov> Submitted changes will take effect January 1, 2021.

### 2021 Plan Elections

Health Insurance	UnitedHealthcare
<i>Please make a selection or decline coverage</i> <input type="checkbox"/> High Deductible Health Plan <input type="checkbox"/> Choice Plus Health Plan (Date of Hire prior to 1/1/17) <input type="checkbox"/> Decline health coverage	<i>Please select your Dependent Coverage Level</i> <input type="checkbox"/> Employee Only <input type="checkbox"/> Family Coverage

Dental Plan	Delta Dental
<i>Please make a selection or decline coverage</i> <input type="checkbox"/> Delta Dental Standard <input type="checkbox"/> Delta Dental Exclusive <input type="checkbox"/> Decline dental coverage	<i>Please select your Dependent Coverage Level</i> <input type="checkbox"/> Employee Only <input type="checkbox"/> Family Coverage

Vision Plan	Superior Vision
<i>Please make a selection or decline coverage</i> <input type="checkbox"/> Enroll <input type="checkbox"/> Decline vision coverage	<i>Please select your Dependent Coverage Level</i> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus One <input type="checkbox"/> Family Coverage

Dependent Care Flexible Spending Account
<i>If you wish to contribute to a Dependent Care Flexible Spending Account in 2021, please complete this section. Contribution elections do not carry over year-to-year so if you wish to contribute next year, you will need to complete a new election form.</i>
<input type="checkbox"/> Yes, I elect the Dependent Care FSA. <input type="checkbox"/> Decline Dependent Care FSA.
<b>Dependent Care FSA Pay period election of \$_____.</b> This amount will be deducted each pay period for 26 pay periods in 2021.

Healthcare Flexible Spending Account
<i>If you wish to contribute to a Healthcare Flexible Spending Account in 2021, please complete this section. Contribution elections do not carry over year-to-year so if you wish to contribute next year, you will need to complete a new election form.</i>
<input type="checkbox"/> Yes, I elect the Healthcare FSA. <input type="checkbox"/> Decline Healthcare FSA.
<b>Healthcare FSA Pay Period election of \$_____.</b> This amount will be deducted each pay period for 26 pay periods in 2021.

**Health Savings Account** – *You may not enroll in this option if you are not enrolled in the High Deductible Health Plan.*

- Yes, I elect to contribute to a Health Savings Account and choose contribute funds
- No, I do not wish to contribute.

**Health Savings Account Pay Period Contribution \$** \_\_\_\_\_ **. This amount will be deducted each pay period for 26 pay periods in 2021.**

**Supplemental Term Life**

**Voya Financial**

*Please make a selection or decline coverage*

- Enroll
- Decline coverage

If you are currently enrolled, you can increase one level of \$25,000 each annual open enrollment without medical underwriting. If you are a late enrollment, you are subject to medical underwriting approval before coverage is in place.

*For new elections, once your enrollment is confirmed, you will be contacted by Human Resources to enter beneficiary information in Self Service.*

*Please select your desired supplemental life coverage Level:*

- \$25,000
- \$50,000
- \$75,000
- \$100,000
- \$125,000
- \$150,000

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## Dependents / Benefit Recipients

Please review your currently enrolled dependents for insurance in Self Service and check one of the boxes below.

- I have reviewed my currently enrolled dependents / benefit recipients and have no changes to submit for Open Enrollment. I understand that should my circumstances change, I must notify Human Resources within 30 days of the Life Event to update my dependent / benefit recipients.
- I have enrolled dependent / benefit recipient changes to submit.
- N/A: I do not have any dependents / benefit recipients.

Please enter the information below for any dependent / benefit recipient changes. If enrolling a new dependent / benefit recipient, please include your supporting legal documentation with your completed election form. If more rows needed, please copy this page.

Full Name	Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other: _____	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Social Security Number	Date of Birth (MM/DD/YY)	Enroll Health <input type="checkbox"/> Yes <input type="checkbox"/> No	Enroll Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	Enroll Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name	Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other: _____	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Social Security Number	Date of Birth (MM/DD/YY)	Enroll Health <input type="checkbox"/> Yes <input type="checkbox"/> No	Enroll Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	Enroll Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
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**ACKNOWLEDGEMENT AND AGREEMENT:**

I enroll (or decline to enroll) in the Benefit Enrollments above which will be provided by the Group Plans for which I am eligible. I authorize Waukesha County to deduct from my pay the amount of the required employee contributions and voluntary elections as indicated. I understand that my elections as indicated above will remain in effect for the entire plan year and that I may only make mid-year changes in my election if I have an eligible qualifying event and I notify Waukesha County within 30 days of the event. I understand that I may change my elections during any subsequent annual enrollment period, with the changes to be effective the following January 1st. I understand my deductions will be taken on a pre-tax basis unless I contact Human Resources to enroll in post-tax deductions.

I hereby certify that the information shown above is true and correct. I understand that any false information may result in my coverage being cancelled and that I may be responsible to reimburse Waukesha County for any benefits paid to me. Waukesha County reserves the right to rescind coverage should the above information prove to be false or inaccurate, and to take any other disciplinary action Waukesha County deems appropriate up to and including termination of employment.

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**Employee Signature**

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**Date**

**Submitting Your Election Form:**

DO NOT SEND YOUR COMPLETED FORM BACK VIA INTEROFFICE MAIL or from your personal email accounts. These are not secure options and you are responsible for ensuring the delivery of your documents.

**Return your Election Form via the following options:**

1. Using your Waukesha County email account, upload and send your completed open enrollment form back to [HROpenEnrollment@waukeshacounty.gov](mailto:HROpenEnrollment@waukeshacounty.gov).
2. Mail the form back to Human Resources using the provided envelope in your packet.
3. Hand deliver your form to the Human Resources Office in Administration Center Rm 160

Contact Human Resources with questions by calling (262) 548-7044 or be emailing [HROpenEnrollment@waukeshacounty.gov](mailto:HROpenEnrollment@waukeshacounty.gov)

**Deadline to Submit Form: October 31, 2020**