2024 Waukesha County Annual Open Enrollment Election Form

Employee Name: _____

Street Address: _____

City, State, Zip: _____

All regular full-time and regular part-time employees must submit an Open Enrollment Election form again for 2024 coverage to accept or decline each offered line of coverage.

Completed election forms are due back to Human Resources by **October 20, 2023.** All 2024 elections must be completed on this form and will not be submitted via Self Service.

Please refer to your 2024 Open Enrollment Guidebook for more information regarding plan design, costs, or contribution limits. Detailed benefit information is also available on online at www.waukeshacounty.gov/openenrollment or on the County Intranet Connection (HR > Benefits).

Please 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, 2024.

Covered Dependents for Insurance

1. Are you adding or removing any dependents from insurance coverage during open enrollment?

□ YES (Complete Dependent Changes below)   □ NO

Dependent Changes:

1. Complete fields below for all dependents being added or removed from coverage.
2. For all new dependent additions, a copy of the birth certificate for a child and marriage certificate for a spouse are required.

Full Name	**Relationship to Employee:** ☐ Spouse ☐ Child ☐ Step Child ☐ Other: _______________	**Gender** ☐ **F** ☐ **M**	**Social Security Number**	**Date of Birth (MM/DD/YY)**	**Enroll Health** ☐ **Yes** ☐ **No** **Enroll Dental** ☐ **Yes** ☐ **No**	**Enroll Vision** ☐ **Yes** ☐ **No** **Enroll Accident** ☐ **Yes** ☐ **No**	**Enroll Hospital** ☐ **Yes** ☐ **No**
Full Name	**Relationship to Employee:** ☐ Spouse ☐ Child ☐ Step Child ☐ Other: _______________	**Gender** ☐ **F** ☐ **M**	**Social Security Number**	**Date of Birth (MM/DD/YY)**	**Enroll Health** ☐ **Yes** ☐ **No** **Enroll Dental** ☐ **Yes** ☐ **No**	**Enroll Vision** ☐ **Yes** ☐ **No** **Enroll Accident** ☐ **Yes** ☐ **No**	**Enroll Hospital** ☐ **Yes** ☐ **No**
Full Name	**Relationship to Employee:** ☐ Spouse ☐ Child ☐ Step Child ☐ Other: _______________	**Gender** ☐ **F** ☐ **M**	**Social Security Number**	**Date of Birth (MM/DD/YY)**	**Enroll Health** ☐ **Yes** ☐ **No** **Enroll Dental** ☐ **Yes** ☐ **No**	**Enroll Vision** ☐ **Yes** ☐ **No** **Enroll Accident** ☐ **Yes** ☐ **No**	**Enroll Hospital** ☐ **Yes** ☐ **No**
Full Name	**Relationship to Employee:** ☐ Spouse ☐ Child ☐ Step Child ☐ Other: _______________	**Gender** ☐ **F** ☐ **M**	**Social Security Number**	**Date of Birth (MM/DD/YY)**	**Enroll Health** ☐ **Yes** ☐ **No** **Enroll Dental** ☐ **Yes** ☐ **No**	**Enroll Vision** ☐ **Yes** ☐ **No** **Enroll Accident** ☐ **Yes** ☐ **No**	**Enroll Hospital** ☐ **Yes** ☐ **No**

Health Savings Account (HSA) – Only available for HDHP participants. Employees can visit Employee Self Service to update their contribution at any time throughout the year. When updating your employee contribution for 2024, please be sure to use an effective date of 12/16/2023 for the first pay date in 2024.

2024 Maximum Amounts: Single: $4,150 / Family: $8,300 / Age 55 Catch up: Additional $1,000

Health Insurance

UnitedHealthcare

Please make a selection or decline coverage

- ☐ High Deductible Health Plan
- ☐ Choice Plus Health Plan (**Date of Hire prior to 1/1/17**)
- ☐ Health Reimbursement Option (HERO)
- ☐ Decline health coverage

Please select your Dependent Coverage Level

- ☐ Employee Only
- ☐ Family Coverage (*Employee and at least 1 other person*)

Dental Insurance

Delta Dental

Please make a selection or decline coverage

- ☐ Delta Dental Standard
- ☐ Delta Dental Exclusive
- ☐ Decline dental coverage

Please select your Dependent Coverage Level

- ☐ Employee Only
- ☐ Family Coverage (*Employee and at least 1 other person*)

Vision Insurance

National Vision Administrators (NVA)

Please make a selection or decline coverage

- ☐ Enroll
- ☐ Decline vision coverage

Please select your Dependent Coverage Level

- ☐ Employee Only
- ☐ Employee Plus One (*Employee and at least 1 other person*)
- ☐ Family Coverage (*Employee and at least 2 other people*)

Flexible Spending Accounts

Elect: Dependent Care FSA Pay period election of $_____. This amount is deducted each pay period for 26 pay periods in 2024.

☐ Decline Dependent Care FSA.

Elect: Healthcare FSA Pay period election of $_____. This amount is deducted each pay period for 26 pay periods in 2024.

☐ Decline Healthcare FSA.

Voluntary Benefits

The Standard Insurance Company

Hospital Indemnity

Please make a selection or decline coverage

- ☐ Enroll
- ☐ Decline Hospital Indemnity coverage

Please select your Dependent Coverage Level

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus Child(ren)
- ☐ Family

Accident Insurance

Please make a selection or decline coverage

- ☐ Enroll
- ☐ Decline Accident coverage

Please select your Dependent Coverage Level

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus Child(ren)
- ☐ Family

Critical Illness

Please make a selection or decline coverage

- ☐ Enroll – Choose **ONE** Level of Coverage Only:
- ☐ $10,000
- ☐ $20,000
- ☐ $30,000
- ☐ Decline Critical Illness coverage

Please select your Dependent Coverage Level

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus Child(ren)
- ☐ Family

(Dependent Children automatically covered- no separate election for children is required.)

Voluntary Supplemental Term Life

Please make a selection or decline coverage

- ☐ Enroll
- ☐ Decline coverage

Please circle your desired supplemental life coverage Level:

$25,000 $50,000 $75,000 $100,000 $125,000

$150,000 $175,000 $200,000

If you are currently enrolled in this benefit, you may make a change in your coverage (increase or decrease) once per year during the annual enrollment period without medical underwriting. If you are not currently enrolled, you will be subject medical underwriting prior to coverage taking effect.

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.

_____ _____

Employee Signature **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, attach and send your completed open enrollment form back to HRBenefits@waukeshacounty.gov.
2. Hand deliver your form to the Human Resources Office in Administration Center Rm 160

Contact Human Resources by calling (262) 548-7044 or be emailing HRBenefits@waukeshacounty.gov

Deadline to Submit Form: October 20, 2023