TOMPKINS COUNTY BENEFITS ENROLLMENT/CHANGE FORM

EMPLOYEE INFORMATION

Name:	Date of Hire:	Employee ID#:
SSN:	DOB:	Gender:
Street/PO Box:		Apt/#:
City:	State:	Zip Code:
Email:		Phone:

HEALTH INSURANCE

I want to…

Enroll in Health Ins. →		Cancel Health Ins. →		Enroll Deps. →		Remove Deps. →	

Select Plan Below:

Platinum - Individual →		Platinum - Family →		Silver - Individual →		Silver - Family →	

Spouse/Domestic Partner Information

Spouse/DP Name:			Gender:
SSN:	DOB:	Enroll Spouse / Domestic Partner →	
Date of Marriage or Divorce:		Remove Spouse / Domestic Partner →	

Dependent Information

Child Name	Gender	SSN	DOB	Enroll	Remove

DENTAL INSURANCE (Sunrise Dental Available to Blue Collar Only)

I want to…

Enroll in Dental Ins. →		Cancel Dental Ins. →		Enroll Deps. →		Remove Deps. →	

Select Plan Below:

Dutchess - Individual →		Sunrise - Individual →		BCBS Low - Ind. →		BCBS High - Ind. →	
Dutchess - Family →		Sunrise - Family →		BCBS Low - Fam. →		BCBS High - Fam. →	

Spouse/Domestic Partner Information

Spouse/DP Name:			Gender:
SSN:	DOB:	Enroll Spouse / Domestic Partner →	
Date of Marriage or Divorce:		Remove Spouse / Domestic Partner →	

Dependent Information

Child Name	Gender	SSN	DOB	Enroll	Remove

PLATINUM VISION INSURANCE

I want to…

Enroll in Vision Ins. →		Cancel Vision Ins. →		Enroll Deps. →		Remove Deps. →	

Select Plan Below:

Platinum Vision - Individual →		Platinum Vision - Family →	

Spouse/Domestic Partner Information

Spouse/DP Name:		Gender:	
SSN:	DOB:	Enroll Spouse / Domestic Partner →	
Date of Marriage or Divorce:		Remove Spouse / Domestic Partner →	

Dependent Information

Child Name	Gender	SSN	DOB	Enroll	Remove

FLEXIBLE SPENDING ACCOUNTS (2026 Healthcare FSA Max Rollover: $660.00)

Account Type	Min. Election	Max. Election	# of Pay Periods	$ Annual	$ Per Pay
Healthcare FSA	$10.00 per Pay	$3,300.00 Annual	26		
Dependent Care FSA	$10.00 per Pay	$5,000.00 Annual	26		

If there is a calculation discrepancy, the annual election will be used, and the per pay period amount recalculated.

Dependent Eligibility Verification Requirements

- If you are enrolling a Spouse or Domestic Partner, you must attach a copy of your Marriage Certificate, Certificate of Domestic Partnership, or Affidavit of Domestic Partnership (contact HR for Affidavit).
- If you are enrolling any Dependent Children (including step children, children of a domestic partner or any children over whom you have custody), you must attach copies of birth certificate(s) and copies of adoption paperwork or court order of custody (if applicable).

Disclaimer and Release

- My signature on this form confirms my intention to enroll in and/or cancel the coverage(s) indicated on this form.
- I authorize payroll deductions for any benefits elected.
- I understand that I cannot change or revoke this agreement during the plan year unless I experience a qualifying life event.
- FSA Disclaimers: I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive; upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: _____ **Date:** _____

RETURN THIS FORM BY EMAIL TO BENEFITS@TOMPKINS-CO.ORG OR BY FAX TO 607-274-5401