TOMPKINS COUNTY BENEFITS ENROLLMENT/CHANGE FORM

Employee Information

Name:	Date of Hire:	EMP ID:
Email:	Phone:	
Social Security Number:	Date of Birth:	Gender:
Full Address:		

PLATINUM HEALTH INSURANCE

I want to...

	Enroll in Health Insurance		Cancel Health Insurance		Add Dependents		Remove Dependents

Spouse/Domestic Partner Information

Spouse/DP Name:	Relationship: Spouse		Domestic Partner		
Social Security Number:	Date of Birth:		Gender:		
	Add Spouse/Domestic Partner		Remove Spouse/Domestic Partner		

Dependent Information

Child Name	SSN	DOB	Gender	Add	Remove

DUTCHESS DENTAL INSURANCE (SUNRISE FOR BLUE COLLAR)

I want to...

	Enroll in Dental Insurance		Cancel Dental Insurance		Add Dependents		Remove Dependents

Spouse/Domestic Partner Information

Spouse/DP Name:	Relationship: Spouse		Domestic Partner		
Date of Marriage: / /					
Social Security Number:	Date of Birth:		Gender:		
	Add Spouse/Domestic Partner		Remove Spouse/Domestic Partner		

Dependent Information

Child Name	SSN	DOB	Gender	Add	Remove

PLATINUM VISION INSURANCE

I want to...

	Enroll in Vision Insurance		Cancel Vision Insurance		Add Dependents		Remove Dependents

Spouse/Domestic Partner Information

Spouse/DP Name:	Relationship: Spouse		Domestic Partner		
Social Security Number:	Date of Birth:		Gender:		
	Add Spouse/Domestic Partner		Remove Spouse/Domestic Partner		

Dependent Information

Child Name	SSN	DOB	Gender	Add	Remove

FLEXIBLE SPENDING ACCOUNTS

NOTE: Healthcare FSA funds may be used for medical, dental, vision and Rx expenses for all tax dependents in your family, and up to $660 in unused funds will roll over to the next year if you are still enrolled in a Healthcare FSA.
The Dependent Care FSA is for daycare expenses for children up to age 13.

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

** 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:** _____

Additional Dependents

Child Name	SSN	DOB	Gender	Add	Remove
Benefit(s) to Add/Remove:					
Child Name	SSN	DOB	Gender	Add	Remove
Benefit(s) to Add/Remove:					
Child Name	SSN	DOB	Gender	Add	Remove
Benefit(s) to Add/Remove:					
Child Name	SSN	DOB	Gender	Add	Remove
Benefit(s) to Add/Remove:					