City of Newton Enrollment Form
Plan Year: July 1, 2024 - June 30, 2025

Personal Information

Last Name	First Name	MI

Address	City	State	Zip

Date of Birth	Social Security Number	Phone	Cell Phone
/ /	- -	( )	( )

Job Title/Position	☐ Full Time	Email Address

Date of Hire	Marital Status		
/ /	☐ Single	☐ Married	

Dependent Information

Spouse Name		DOB		SS#		Sex	(M / F)
Child Name		DOB		SS#		Sex	(M / F)
Child Name		DOB		SS#		Sex	(M / F)
Child Name		DOB		SS#		Sex	(M / F)
Child Name		DOB		SS#		Sex	(M / F)
Child Name		DOB		SS#		Sex	(M / F)

With this form you will choose benefits coverage for yourself and your family. If you waive (decline) coverage for yourself or your dependents now, you will NOT be able to get coverage until the next open enrollment period or within 30 days of a qualifying status change (e.g. death, birth, marriage, loss of other coverage, etc.) and there may be waiting periods. The costs are listed below and are deducted from your paycheck. Details of the cost of the coverages are listed below. Information about the plans can be found in your benefits guide and are available upon request from the HR department.

Your Medical, Dental and Vision Election Choices

BlueCross BlueShield of North Carolina will provide medical benefits. Delta Dental will administer your dental benefits and Community Eye Care will administer your vision benefits. Please mark (X) in the boxes below which corresponds to the plan option and coverage level desired. If you elect to waive (decline) medical coverage you must show proof of 'other coverage' which can include coverage through your spouse, individual coverage, or Medicare.

Rates below are 'weekly' deductions

	EE Only		EE + Spouse		EE + One Child		EE + Children		EE + Family		Waive
Medical Plan (BCBSNC)	☐	$0.00	☐	$166.85	☐	$64.38	☐	$128.77	☐	$320.77	☐

	EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
Dental Premium (Delta Dental)	☐	$8.02	☐	$14.72	☐	$13.96	☐	$26.38

Rates below are 'monthly' deductions

	EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
Vision Premium - Eyewear Plan (CEC)	☐	$6.43	☐	$12.64	☐	$11.98	☐	$19.28
Vision Premium - Comprehensive Plan (CEC)	☐	$7.96	☐	$15.36	☐	$14.57	☐	$23.32

Waive (Decline) Medical Coverage: _____

Prior Coverage Information / Medicare Information

Are you currently enrolled in the City of Newton Medical Plan? ☐ Yes ☐ No

If NO, do you currently have medical coverage elsewhere? ☐ Yes ☐ No

If YES, please tell us who you currently have medical coverage through, including if you are currently on Medicare.

Name and Address of 'other' Medical Insurance Carrier _____

_____

Name of Policyholder _____ Group or Policy No. _____

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Acknowledgment

I acknowledge that my pre-tax elections cannot be changed once the plan year has begun unless there is a qualified status change. A qualified status change includes: changes in marital status, changes regarding dependents, changes in employment status, changes in residence or work site that affect eligibility, changes in work schedule, or a dependent ceasing to satisfy the eligibility conditions for coverage. I understand that the pre-tax benefit options elected above will remain in force for the Plan Year unless my family status changes. If I terminate employment, I understand that the Plan Document will control any continued participation under this Plan. I agree to all the above in order to continue my coverage for these benefits through the City of Newton. I further agree that I have been provided all my rights due a participant in an employer sponsored benefits program.

Employee Signature	**Date**