

Benefits Election✓ **Checklist** ✓**DeKalb County Group Benefit Plan (DCGBP)
October 2008 Open Enrollment (OE)****Checklist Instructions:**

This is an "Active" Open Enrollment (OE) Period. Each employee must complete, sign, and submit this OE Benefit Election Checklist along with any program provider forms. Employees are to return the checklist and applications to their Departmental Payroll / Personnel Administrator (PPA).

The OE Period Announcement describes what the DCGBP current and eligible participants must do during the month of October 2008. Summary Plan Description (SPD) information packets representing all programs offered are available from the Departmental PPA, the Employee Services Center (ESC), plus the OE Information Forums. The OE Information Forums Location Schedule is included with the OE Announcement and October issue of the Risk Management News newsletter.

Remember to make your benefits program elections as early in the month of October as possible. The earlier in the month of October you submit the checklist & program specific application forms, the higher the chance that you and your dependents will receive their membership ID cards by January 1, 2009, the inception date of the new plan year.

EMPLOYEE IDENTIFICATION		
Last Name, First Name, MI:	Employee ID#:	Department Name:
Telephone #:	E-mail Address:	

Domestic Partner employees' same gender partners are eligible for coverage in many of the plans offered. Declaration of Domestic Partnership form & joint residency verification are required.

Table 1 MAJOR MEDICAL (MM) PLANS				
<input type="checkbox"/>	I DECLINE MAJOR MEDICAL COVERAGE.		<i>Refer to HIPAA Special Enrollment Notice.</i>	
ACTIVE EMPLOYEE		BIWEEKLY PAYROLL DEDUCTION RATES		
Check a box <input checked="" type="checkbox"/> in Col. 1 to elect a program.		Check the box <input checked="" type="checkbox"/> next to the desired program participation rate:		
Col 1	Active EE MM Program Options	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
<input type="checkbox"/>	CIGNA High PPO	<input type="checkbox"/> \$ 47.92	<input type="checkbox"/> \$124.12	<input type="checkbox"/> \$148.56
<input type="checkbox"/>	CIGNA Low PPO	<input type="checkbox"/> \$ 46.39	<input type="checkbox"/> \$120.15	<input type="checkbox"/> \$143.81
<input type="checkbox"/>	CIGNA HMO	<input type="checkbox"/> \$ 58.42	<input type="checkbox"/> \$151.29	<input type="checkbox"/> \$180.50
<input type="checkbox"/>	Kaiser Permanente (KP) HMO Current Member without 2009 Status Changes *			
<input type="checkbox"/>	KP HMO New or Current Member with Status Changes (requires KP application)	<input type="checkbox"/> \$ 50.74	<input type="checkbox"/> \$131.45	<input type="checkbox"/> \$157.07

Table 2 DENTAL INSURANCE		BIWEEKLY DEDUCTION RATES		
<input type="checkbox"/>	I DECLINE DENTAL COVERAGE.			
Check a box <input checked="" type="checkbox"/> in Col. 1 to elect a program.		Check the box <input checked="" type="checkbox"/> next to the desired program participation rate:		
Col 1	United Concordia Insurance (UCCI)	Employee Only	Employee + 1 Dependent	Employee + Family
<input type="checkbox"/>	UCCI High Dental	<input type="checkbox"/> \$3.68	<input type="checkbox"/> \$7.36	<input type="checkbox"/> \$11.05
<input type="checkbox"/>	UCCI Low Dental	<input type="checkbox"/> \$2.99	<input type="checkbox"/> \$5.97	<input type="checkbox"/> \$7.47

Table 3 VISION INSURANCE		BIWEEKLY DEDUCTION RATES		
<input type="checkbox"/>	I DECLINE VISION COVERAGE.			
Check a box <input checked="" type="checkbox"/> in Col. 1 to elect a program.		Check the box <input checked="" type="checkbox"/> next to the desired program participation rate:		
Col 1	EyeMed Vision Care	Employee Only	Employee + 1	Employee + Family
<input type="checkbox"/>	EyeMed High	<input type="checkbox"/> \$2.77	<input type="checkbox"/> \$5.27	<input type="checkbox"/> \$7.74
<input type="checkbox"/>	EyeMed Low	<input type="checkbox"/> \$2.26	<input type="checkbox"/> \$4.29	<input type="checkbox"/> \$6.29

Employees should return the Benefits Election Checklist along with program specific Application / Change forms to their Payroll Personnel Coordinators.

For more specific questions, contact the Employee Services Center: Voice: 404.371.4968 / 4972 / 2099 Fax: 404.371.2910

DCGBP Benefits Election Checklist Form

Table 4		BASIC LIFE INSURANCE	
<input type="checkbox"/>	I DECLINE BASIC LIFE INSURANCE COVERAGE.		
Check a box <input checked="" type="checkbox"/> in Col. 1 to elect a program.		(Rate Per \$1,000 Life Benefit)	
Col 1	Hartford Life Basic	Active: \$0.13	Dependent: \$1.50
<input type="checkbox"/>	<u>Current Member</u> without 2009 Coverage Changes	<i>Basic Life participants with no status changes automatically enroll in the Hartford program.</i>	
<input type="checkbox"/>	New or Current Member with Coverage Changes*	Requires Application / Change Form	

Table 5		SUPPLEMENTAL LIFE INSURANCE	
<input type="checkbox"/>	I DECLINE SUPPLEMENTAL LIFE COVERAGE.	<i>(This checked box will terminate current Unimerica & indicate no 2009 Supplemental Life participation)</i>	
Col 1	Hartford Life Supplemental	See Hartford Supplemental Life Insurance Brochure for Rate Information.	
<input type="checkbox"/>	<u>Current Member</u> without 2009 Coverage Changes	<i>No status change Basic Life participants will automatically be enrolled in Hartford program.</i>	
<input type="checkbox"/>	New or Current Member with Coverage Changes*	Requires Application / Change Form	

Table 6		SHORT-TERM DISABILITY INSURANCE	
<input type="checkbox"/>	I DECLINE SHORT-TERM DISABILITY (STD) COVERAGE.	<i>(This checked box will terminate current AFLAC & indicate No STD participation effective 1/1/2009)</i>	
Check a box <input checked="" type="checkbox"/> in Col. 1 to elect a program.			
Col 1	Colonial Insurance Co.	See Colonial Ins. Co. STD Brochure for Rate Information.	
<input type="checkbox"/>	<u>Current Member</u> without 2009 Coverage Changes	<i>(AFLAC STD participants with no status changes will automatically enroll in Colonial STD program with current 2008 coverage values for 2009; No forms are necessary.)</i>	
<input type="checkbox"/>	New or Current Member with Coverage Changes	(Requires Application / Change Form)	

Table 7		ACCIDENT INSURANCE	
<input type="checkbox"/>	I DECLINE ACCIDENT COVERAGE.	<i>(If you currently are enrolled, checking this box will terminate current accident coverage effective 1/1/2009.)</i>	
Check a box <input checked="" type="checkbox"/> in Col. 1 to elect a program.			
Col 1	AFLAC	See AFLAC Accident Brochure for Rate information.	
<input type="checkbox"/>	Current Member	Automatic Accident Insurance participation for plan year 2009.	
<input type="checkbox"/>	New Member 2009	➤ Requires Application	

Employee Signature:	Date:	Dept. PPA Initials:	PPA Date:	ES Initials:	ES Date:
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