WASHTENAW COUNTY ROAD COMMISSION
BENEFITS ENROLLMENT FORM

Please complete this benefits enrollment form in its entirety when enrolling or making changes to your benefits. If there is a life event change, you must submit this completed form and backup documentation within 30 days of the qualifying event.

PERSONAL INFORMATION

Last Name	First Name	Middle	Social Security Number

Address	City	Zip

Home Phone Number	Cell Phone Number	Marital Status ☐ Single ☐ Married	Date of Birth

MEDICAL ELECTIONS

See Summary of Benefits and Coverage for more information regarding each PPO plan.

☐ Blue Cross Blue Shields Community Blue **PPO 4** & $0/$30 Rx Coverage	☐ Blue Cross Blue Shields Community Blue **PPO 7** & $0/$30 Rx Coverage	☐ Waive Medical Coverage[1]

[1] I elect to waive medical coverage and participate in the buy-out program and will provide proof of other coverage. I also understand that I may enroll if I experience a qualifying event.

DENTAL ELECTIONS

See Summary of Coverage for more information regarding each plan.

☐ **Base** – Maximum benefit of $1,000 per calendar year per person/$1,000 orthodontia lifetime maximum	☐ **Enhanced** – Maximum benefit of $2,000 per calendar year per person/$2,000 orthodontia lifetime maximum

VISION ELECTIONS

See Summary of Coverage for more information regarding each plan.

☐ **Base** – $130 annual materials allowance; frequency exams: 12 mos./lenses: 12 mos./frames: 24 mos.	☐ **Enhanced** – $200 annual materials allowance; frequency exams: 12 mos./lenses: 12 mos./frames: 12 mos.

DEPENDENT INFORMATION

Last Name	First Name	Gender (M/F)	DOB *(if new enrollee)*	SSN *(if new enrollee)*	Relationship Code[2]	Check Coverage		
					CH	☐ Medical	☐ Dental	☐ Vision
						☐ Medical	☐ Dental	☐ Vision
						☐ Medical	☐ Dental	☐ Vision
						☐ Medical	☐ Dental	☐ Vision
						☐ Medical	☐ Dental	☐ Vision
						☐ Medical	☐ Dental	☐ Vision

[2] Relationship Code: CH – Contract Holder, S – Spouse, D – Dependent Child

FLEXIBLE SPENDING ACCOUNTS (FSA)

Select one option for Health Care FSA and one option for Dependent Care FSA.

Health Care FSA – Covers eligible health care expenses for you, your spouse and eligible dependents. (Max. $2,650/year)

☐ Enroll in Medical FSA - Annual Election: $ ____________
☐ Waive Medical FSA

Dependent Care FSA – Covers eligible dependent care expenses for your eligible dependents. (Max. $5,000/household/year)

☐ Enroll in Dependent Care FSA - Annual Election Amount: $ ____________
☐ Waive Dependent Care FSA

OTHER MEDICAL COVERAGE

Do you, your spouse or dependent(s) maintain other medical coverage or Medicare? ☐ Yes (please attach a copy of the card) ☐ No

VERIFICATION

I have reviewed my election option(s) and agree to the terms and conditions listed there. The information listed above is correct to the best of my knowledge.

Employee Signature	Date Signed