Open Enrollment 2020

Open Enrollment Check list

This document is to help you think through your benefits. If you are going to attend a help session at City Hall, please come with this completed and all the required information available.

NOTICE!

THIS CHECKLIST DOES NOT INCLUDE ALL THE DETAILS FOR EACH POLICY. PLEASE CONSULT THE POLICY HANDOUTS FOR SPECIFIC INFORMATION REGARDING THE BENEFIT YOU HAVE QUESTIONS ABOUT.

https://ESS.COLUMBUS.IN.GOV/MSS/LOGIN.ASPX

Username is your employee ID. My Username is _____

If you forget your password, click on the "Forgot your password?" link.

Type your user name into the box and click "Retrieve hint"

HEALTH INSURANCE:

I am choosing ☐No Changes ☐PPO ☐ HDHP ☐Decline Coverage

☐Employee Only ☐Employee + Child(ren) ☐Employee + Spouse☐Family

HEALTH INSURANCE DEPENDENTS:

☐I entered them last year, so I don't need to do it again.

☐I didn't enter them last year, so I need to have their name, date of birth and social security number.

DENTAL INSURANCE:

I am choosing ☐No Changes ☐High ☐ Low ☐Decline Coverage

☐Employee Only ☐Employee + One ☐Employee + More than One

DENTAL INSURANCE DEPENDENTS:

☐I entered them last year, so I don't need to do it again.

☐I didn't enter them last year, so I need to have their **name, date of birth and social security number.**

VISION INSURANCE:

I am choosing ☐No Changes ☐VSP ☐ Davis ☐Decline Coverage

☐Employee Only ☐Employee + One ☐Employee + More than One

VISION INSURANCE DEPENDENTS:

☐I entered them last year, so I don't need to do it again.

☐I didn't enter them last year, so I need to have their **name, date of birth and social security number**.

FSA MEDICAL REIMBURSEMENT:
Did you elect PPO for your health insurance? If yes, please continue. If no, please skip.

I am eligible to choose the FSA Medical Reimbursement and I am choosing ☐No Changes

☐Increase amount to _____ ☐Decrease amount to_____ ☐Decline Coverage

FSA DEPENDENT CARE:
Did you elect PPO for your health insurance? If yes, please continue. If no, please skip.

I am eligible to choose the FSA Dependent Care and I am choosing ☐No Changes

☐Increase amount to _____ ☐Decrease amount to_____ ☐Decline Coverage

HEALTH SAVINGS ACCOUNT:
Did you elect HDHP (High Deductible) for your health insurance? If yes, please continue. If no, please skip.

I am eligible to choose the Health Savings Account and I am choosing ☐No Changes

☐Increase amount to _____ ☐Decrease amount to_____ ☐Decline Coverage

☐I currently have an HSA with First Financial and do not need to complete the application.

☐I am new to an HSA and need to complete the application. I understand that I will need to complete this separately from open enrollment and to send the application and a copy of my driver's license to humanresources@columbus.in.gov within 48 hours of electing an HSA.

FLEX LIMITED (DENTAL/VISION):
Did you elect PPO for your health insurance? If yes, please continue. If no, please skip.

I am eligible to choose the FSA Medical Reimbursement and I am choosing ☐No Changes

☐Increase amount to _____ ☐Decrease amount to_____ ☐Decline Coverage

BASIC LIFE AND ADD:
This is the City provided life insurance. There is NO cost to you – we just need your age group and your beneficiaries.

☐No Changes to my age or beneficiaries

☐I need to change my age bracket

☐I need to change my beneficiaries (and understand that I will have to provide their name, date of birth, and social security number)

SUPPLEMENTAL LIFE:
This is the additional (voluntary) life insurance. I understand that the premium is my responsibility.
***NEW for 2021 – AD&D coverage included in the Life Insurance benefit. The AD&D benefit amount will match the Life benefit amount*
***All increases must be in $1,000 increments*

☐No Changes to my amount of coverage or my beneficiaries.

☐I do not currently have Supplemental life and I want to take advantage of the one-time guaranteed issue amount of $100,000 with no medical questions.

☐I want to take advantage of the $10,000 Guaranteed Increase in Benefits with no medical questions.

☐I want to increase my benefit amount by more than $10,000 and understand that I will be required to complete an Evidence of Insurability for OneAmerica. This document will go to the company's underwriting department and the increase may be denied.

☐Current Salary _____ x 5 = _____ is the maximum benefit for which I can apply as long as it is does not exceed $500,000.

☐I want to cancel my supplemental (voluntary life) completely. Decline coverage.

CHILD LIFE:
This is the additional (voluntary) life insurance. I understand that I must carry supplemental life on myself before I am eligible to carry Child Life and the premium is my responsibility.
**** I understand that this one (1) policy covers all of my child under 26 years of age.*

☐No Changes

☐I want to carry life insurance in the guaranteed amount of $10,000 on all of my children.

☐I want to carry life insurance in the guaranteed amount of $7,500 on all of my children.

☐I want to carry life insurance in the guaranteed amount of $5,000 on all of my children.

☐I want to carry life insurance in the guaranteed amount of $2,500 on all of my children.

☐Decline Coverage

SPOUSE LIFE:

This is the additional (voluntary) life insurance. I understand that I must carry supplemental life on myself before I am eligible to carry Spouse Life and the premium is my responsibility.

***Spouse life can match the Employee's supplemental life UP TO $20,000 increments of $500 with a minimum amount of $10,000*

☐No Changes

☐I want to carry life insurance in the guaranteed amount of $10,000 on my spouse and I am carrying at least $10,000 on myself.

☐I want to carry life insurance in the guaranteed amount of $20,000 on my spouse and I am carrying at least $20,000 on myself.

☐I want to carry life insurance in the amount of _____ and that amount is no less than $10,000 and no more than $20,000. I am carrying at least that amount on myself.

☐Decline Coverage