2025 Active Employee Benefit Election/Change Form

Employee Name (Last, First, M.I.)	Employee ID #	Effective Date of Coverage/Change

Phone Number	Email Address

Current Coverage	Type of Change: ☐ Add Coverage/Dependent(s) ☐ Remove Dependent(s)/Cancel Coverage

Qualified Family Status Change:
☐ Birth/Adoption/Guardianship
☐ Change in Marital Status
☐ Change in spouse/dependent employment
☐ Other

Required Documentation:
Copy of birth certificate/Adoption/Guardianship
Marriage-copy of marriage certificate/license; Divorce- copy of Final Judgement Divorce Decree
Proof of gain/loss of coverage including effective date on employer letterhead, and above documents

I ELECT THE FOLLOWING BENEFITS: (Bi-Weekly Rates)

Medical Insurance United Healthcare	City Plan with HRA	Single ($0.00)	Family ($238.37)		☐ Waive/Cancel Coverage
	Simple Wellness Plan	Single ($21.25)	Family ($280.86)		
Dental Insurance Humana	☐ DHMO	Single ($6.29)	Individual + 1 ($12.45)	Family ($22.13)	☐ Waive/Cancel Coverage
	☐ PPO	Single ($14.88)	Individual + 1 ($27.84)	Family ($46.08)	
Vision Insurance SuperiorVision by Metlife	PPO	☐ Single ($2.27)	☐ Individual + 1 ($4.55)	☐ Family ($7.60)	☐ Waive/Cancel Coverage

COVERED DEPENDENTS (Add or Remove individual)

Last Name, First Name, MI	Relationship	Gender	Date of Birth	Social Security #	
					Medical: ☐ Add ☐ Remove Dental: ☐ Add ☐ Remove Vision: ☐ Add ☐ Remove
					Medical: ☐ Add ☐ Remove Dental: ☐ Add ☐ Remove Vision: ☐ Add ☐ Remove
					Medical: ☐ Add ☐ Remove Dental: ☐ Add ☐ Remove Vision: ☐ Add ☐ Remove
					Medical: ☐ Add ☐ Remove Dental: ☐ Add ☐ Remove Vision: ☐ Add ☐ Remove

Federal law requires notice of COBRA rights to anyone losing coverage. Please provide current address if individual is losing coverage.

Address City, State, Zip

Carefully read the statement below before signing this form

I hereby authorize the City of Tampa to make the changes listed above and adjust my pay accordingly. I understand that should circumstances change regarding my dependents and/or the availability of other health coverage during the plan year, I am obligated to notify Human Resources within thirty one (31) days of the change of circumstances and to immediately assume any monetary obligations that arise because of the change of circumstances. I understand that a deliberate misrepresentation or misstatement of the facts contained on this form may result in termination of medical coverage for a period of one year. I further acknowledge and understand that providing false information is fraud, and if the above answers are misrepresented or contain false information, as an active employee I may be subject to disciplinary action up to and including possible termination of employment.

I verify and certify that the information provided on this form is true and correct.

Employee Signature _____ Date _____

Administrative Use Only

Effective Date:	Oracle:	Provider: