

CITY OF LOCKPORT
2023/2024 BENEFITS ENROLLMENT FORM

NAME: _____ UNION: HICKORY CLUB

ADDRESS: _____

BIRTHDATE: ___/___/___ PHONE # ___-___-___ SS # ___-___-___

INSTRUCTIONS:

- A. Select the coverage that best meets your needs; mark your choice in the box below. Complete the Blue Cross/Blue Shield Enrollment Form.
- B. Complete all necessary sections of this form (front and back): Medical Options, Medical Insurance Waiver, Spouse and Dependent Information.
- C. Sign and date the Certification and return all forms to the Payroll & Benefits Administrator.

MEDICAL OPTIONS:

* Per current union contract in effect for POLICE OFFICERS hired on or after 12/18/2015, new hires may enroll in the POS 200 Class 002, 003 or 004 with the 3-tier prescription co-pay (Option 1, 2 or 3). Such hires must pay 15% of the cost of their selected plan at current applicable rates, via payroll deduction, throughout their employment. Police Officers hired after 1/1/2014 are not eligible for an HRA benefit.

Option 1: POS 200 Class 002/002+ (Choose One)

Office Visit Co-Pay (Choose One)

- Single monthly premium 2023 @ 15% = \$106.16
- Single monthly premium 2024 @ 15% = \$114.87
- Family monthly premium 2023 @ 15% = \$298.56
- Family monthly premium 2024 @ 15% = \$323.04

- Class 002 \$5 Primary/\$10 Specialist
- Class 002+ \$0 Primary/\$15 Specialist

Option 2: POS 200 Class 003/003+ (Choose One)

Office Visit Co-Pay (Choose One)

- Single monthly premium 2023 @ 15% = \$103.47
- Single monthly premium 2024 @ 15% = \$111.96
- Family monthly premium 2023 @ 15% = \$291.03
- Family monthly premium 2024 @ 15% = \$314.89

- Class 003 \$10 Primary/\$10 Specialist
- Class 003+ \$0 Primary/\$20 Specialist
- Class 003+ \$5 Primary/\$15 Specialist

Option 3: POS 200 Class 004/004+ (Choose One)

Office Visit Co-Pay (Choose One)

- Single monthly premium 2023 @ 15% = \$101.49
- Single monthly premium 2024 @ 15% = \$109.81
- Family monthly premium 2023 @ 15% = \$285.34
- Family monthly premium 2024 @ 15% = \$308.74

- Class 004 \$15 Primary/\$15 Specialist
- Class 004+ \$10 Primary/\$20 Specialist

PRESCRIPTION COPAYS FOR ALL PLANS AS FOLLOWS:

\$7 GENERIC / \$15 FORMULARY / \$35 OTHER

MEDICAL INSURANCE WAIVER: (If you elect NO MEDICAL COVERAGE, Option 5)

I hereby certify that I elect NO medical coverage under the BENEFITS PLAN and that I have medical coverage through another source.

Insurance Company: _____ Group #: _____

Signature: _____ Date: _____

SPOUSE & DEPENDENT INFORMATION:

Name (First, M.I., Last – if different)	Social Security #	Relationship	Date of Birth
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___

CERTIFICATION

I certify that by signing and submitting this form, I am making a binding election for plan year beginning 11/1/2023 and ending 10/31/2024. I understand that an election change CANNOT be made unless I experience a qualified status change. I also certify that all information shown on this form is true and correct to the best of my knowledge. I am aware that any unused HRA funds will roll over to the next plan year.

Signature: _____

Date: _____