

**CITY OF LOCKPORT
2023/2024 BENEFITS ENROLLMENT FORM**

NAME: _____ UNION: FIREFIGHTERS (LPFFA Local 963)

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:

FOR FIREFIGHTERS HIRED PRIOR TO 7/1/17 AND NOT YET RETIRED, AS OF 7/1/17.

Option 1: POS 200 Class 001/001+ (Choose One) Office Visit Co-Pay (Choose One)

- Single Class 002 \$5 Primary/\$10 Specialist
- Family Class 002+ \$0 Primary/\$15 Specialist
- Prescription Co-Pay: \$5 mandatory generic, formulary when no generic is available

Option 2: POS 200 Class 002/002+ (Choose One) Office Visit Co-Pay (Choose One)

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

Option 3: POS 200 Class 003/003+ (Choose One) Office Visit Co-Pay (Choose One)

- Single Class 003 \$10 Primary/\$10 Specialist
- Family Class 003+ \$0 Primary/\$20 Specialist
- HRA Single \$250/Family \$500** Class 003+ \$5 Primary/\$15 Specialist

Option 4: POS 200 Class 004/004+ (Choose One) Office Visit Co-Pay (Choose One)

- Single Class 004 \$15 Primary/\$15 Specialist
- Family Class 004+ \$10 Primary/\$20 Specialist
- HRA Single \$250/Family \$500**

PRESCRIPTION COPAYS FOR ALL PLANS EXCEPT CLASS 001 201/201+ 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: _____