CITY OF LOCKPORT
2023/2024 BENEFITS ENROLLMENT FORM

NAME: _____ UNION: AFSCME

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 AFSCME members hired prior to 04/21/2021, you may enroll in the POS 200 - Class 002, 003, 004 with the 3-tier prescription co-pay. The City will contribute $400 for a Single plan and $800 for a family plan to an employee's HRA account for any employee hired before 04/21/2021 enrolled in a qualifying medical plan and with 3 years of service. These new hires must pay 10% of the cost of the premium equivalent, at applicable rates, throughout their employment and do not qualify for an HRA. Check the box of plan you choose, Choose Single or Family and Co-Pay amount to right of plan:

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

◯ Single
◯ Family

Office Visit Co-Pay (Choose One)

◯ Class 002 $5 Primary/$10 Specialist
◯ Class 002+ $0 Primary/$15 Specialist

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

◯ Single
◯ Family

Office Visit Co-Pay (Choose One)

◯ 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)

◯ Single
◯ Family

Office Visit Co-Pay (Choose One)

◯ 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: _____