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 AFSCME Contract ratified on April 21, 2021, new hires may enroll in the POS 200-2, POS 200-3 or POS 200-4 with the 3-tier prescription co-pay (Option 1,2 or 3), without the HRA benefit. Such hire must pay 10% of the cost of his/her selected plan at current applicable rates, via payroll deduction, throughout his/her employment. 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 monthly premium 2023 @ 10% = $ 70.78
◯ Single monthly premium 2024 @ 10% = $ 76.58
Family monthly premium 2023 @ 10% = $199.04
◯ Family monthly premium 2024 @ 10% = $215.36

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 monthly premium 2023 @ 10% = $ 68.98
◯ Single monthly premium 2024 @ 10% = $ 74.64
Family monthly premium 2023 @ 10% = $194.02
◯ Family monthly premium 2024 @ 10% = $209.93

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 monthly premium 2023 @ 10% = $ 67.66
◯ Single monthly premium 2024 @ 10% = $ 73.20
Family monthly premium 2023 @ 10% = $190.23
◯ Family monthly premium 2024 @ 10% = $205.82

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: _____