



Employee Benefits 2010

City of Anaheim

EMPLOYEE INFORMATION

IF CHANGES FOR 2010, PLEASE RETURN THIS FORM WITH COMPLETED APPLICATION BY OCTOBER 21, 2009.

MEDICAL

Please check if NO CHANGE on Medical

| | | | |
|--------------------|--------------------------|--------------------------|--------------------------|
| | SINGLE | 2 PARTY | FAMILY |
| KAISER HEALTH PLAN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AETNA HMO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|
| | SINGLE | 2 PARTY | FAMILY |
| AETNA OAMC (PPO) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AETNA HIGH OPTION OAMC (PPO) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

DECLINE MEDICAL COVERAGE

Please complete the following and attach a copy of the other plan's ID card, enrollment form or similar verification of coverage.

Medical Insurance Carrier _____
 Policy Number _____
 Effective Date of Coverage _____

I hereby waive medical coverage offered by the City of Anaheim for 2010 and state that I am covered by another plan. My signature below indicates my responsibility to contact the City IMMEDIATELY in the event my medical coverage stops. I further understand that the monthly \$125 bonus will be added to my paychecks and that it is taxable.

SIGNATURE _____

DENTAL

Please check if NO CHANGE on Dental

| | | | |
|------------------|--------------------------|--------------------------|--------------------------|
| | SINGLE | 2 PARTY | FAMILY |
| DELTA DENTAL PPO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | |
|-------------------|--------------------------|--------------------------|--------------------------|
| | SINGLE | 2 PARTY | FAMILY |
| DELTACARE USA DMO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

YOUR CURRENT HEALTH PLAN ENROLLMENT IS

DEPENDENT INFORMATION

| Last Name | First Name | Relationship | Date of Birth | Plans | SSN (required) |
|-----------|------------|--------------|---------------|-------|----------------|
|-----------|------------|--------------|---------------|-------|----------------|

SIGNATURE _____

DATE _____

I understand that my benefit elections shown here will be in effect January 1, 2010 through December 31, 2010. I further recognize that I must notify Human Resources promptly when dependents are eligible for benefits. Failure to notify the City of Anaheim may subject me to repayment of premium costs to cover ineligible dependents. I hereby authorize CITY OF ANAHEIM to deduct from my pay amounts I have elected above. My participation in the plan(s) is subject to all the terms and conditions of the plan, as set forth in the plan document and any and all related documents. I understand that I may review the plan documents by contacting the Benefit Administrator. Your share of the cost of benefits reduces your taxable income and reduces the income taxes you pay. This is done automatically unless you contact Human Resources refusing the tax savings.

