# Annual Enrollment this year will be Tuesday, April 23, 2019 through Wednesday, May 1, 2019.

**Annual Enrollment meeting dates and times are listed below. Great news! There will be NO rate increase in any of our benefits. At the beginning of April, you will receive a flyer with more details regarding the meetings and plan changes. Since there is little change in the plan this year, meetings will NOT be mandatory.**

**PLEASE NOTE: In the next two (2) weeks you will receive a statement showing all current coverage you have elected. The statement will be mailed to your home for review so be on the lookout for it. Please make sure Human Resources has your correct address. Once you review the statement, if applicable, please sign the enclosed form stating that you received the statement and check that you are satisfied with your elections. If you need to add or drop coverage, please sign the form and check that you plan to make changes in which you may do so during annual enrollment at the days and times listed. *No matter which applies (keeping current coverage, adding or dropping), please mail your form back to Human Resources by April 1, 2019 in the self-addressed, postage paid envelope that will be enclosed. An example of what you will received is shown below.***

**MARKIII will be handling all of our benefits and enrollment including medical and all voluntary products just like last year. MarkIII enrollers will be on-site at Public Works in the same area.**

**It is very, very important if you need to make any changes to your benefits that you see an enroller on one of the dates below. *After May 1, 2019, no changes can be made unless you have a family status change/qualifying event.* If you want to refresh your memory on any of the voluntary products (Term life, Whole life, Accident, Cancer, Critical Illness, Short-term and Long-term Disability) or the health plan (Medical, Dental and Vision), please be sure to attend one of the sessions. As always, you are welcome to invite your spouse to a session, particularly if your spouse handles most of the benefits.**

## 2019 Annual Enrollment Meeting Schedule

## ALL MEETINGS HELD IN THE PUBLIC WORKS CONFERENCE ROOM:

**Tuesday, April 23, 2019:** 7:30am-8:30am
1:30pm-2:30pm

**Wednesday, April 24, 2019:** 7:30am-8:30am
10am–11am
1:30pm-2:30pm

**Thursday, April 25, 2019:** 8:30am-9:30am
3:00pm-4pm

**ENROLLERS WILL BE ON SITE DAILY STARTING THE FIRST SESSION OF THE DAY UNTIL 5:00PM TUESDAY-THURSDAY**

**Friday, April 28, 2017:** An enroller will be at the Human Resources Department from 8:00am-noon and 1:00pm-5:00pm for anyone desiring to enroll or drop products.

**Monday, April 29, 2019 – Wednesday, May 1, 2019:**
Employees may come by Human Resources and enroll or drop coverage from 8:00am-noon and 1:00pm-5pm.

**Please note: All changes must be made and forms signed no later than 5pm on Wednesday, May 1, 2019. No exceptions!**

**Example of Statement you will receive**

# Confirmation of Benefits

March 04, 2019

**Employee Name:** [redacted]
**Location:** City of Asheboro

**Last Enrollment Method:** Enroller Assisted
**Last Enrollment Date:** 4/26/2018

## Your Benefits

This statement confirms your new benefit elections, covered dependents and beneficiaries based on your benefits eligibility date (or effective date for a qualified status change).

If you did not enroll for benefits during your initial eligibility period as a new hire (or transfer into a benefit-eligible position), your enrollment method will be listed as "Default" above. This means you will only receive default benefit coverage. You must wait until the next annual open enrollment period to elect any other benefits (unless you have a qualified status change as defined by IRS guidelines). If you feel the information on this statement is incorrect, please contact the Human Resources Department.

| Benefit Plan | Current Coverage | Pre-tax | After-tax |
|---|---|---|---|
| Medical | MedCost Medical Plan; Employee Only | $0.00 | $0.00 |
| Dental | MedCost Dental Plan; Employee Only | $0.00 | $0.00 |
| Vision | MedCost Vision; Employee Only | $0.00 | $0.00 |
| Aflac Group Accident Insurance | N/A | $0.00 | $0.00 |
| Aflac Group Hospital Indemnity Insurance | N/A | $0.00 | $0.00 |
| Humana Cancer | Humana Cancer Plan; Employee + Spouse | $17.79 | $0.00 |
| Aflac Group Critical Illness Insurance - Employee | $5,000 | $0.00 | $5.82 |
| Aflac Group Critical Illness Insurance - Spouse | $5,000 | $0.00 | $5.82 |
| Short-Term Disability | N/A | $0.00 | $0.00 |
| Long-Term Disability | N/A | $0.00 | $0.00 |
| Basic Life & AD&D | $20,000 | $0.00 | $0.00 |
| Voluntary Dependent Term Life | $10,000 | $0.00 | $2.12 |
| Term Life - Employee | N/A | $0.00 | $0.00 |
| Term Life - Spouse | N/A | $0.00 | $0.00 |
| Term Life - Child | N/A | $0.00 | $0.00 |
| Texas Life Whole Life | N/A | $0.00 | $0.00 |
| **Total Employee Cost Per Pay Period** | | **$17.79** | **$13.76** |

Please review for accuracy.

**PLEASE CHECK WHICH APPLIES**

___________ **I do NOT need to make any changes to my benefits.**

___________ **I DO need to make changes to my benefits.**

**Signature**______________________________________ **Date**_______________

**If you need to add or make changes to your beneficiary information, please complete the enclosed Beneficiary Designation Form. If you are satisfied with your beneficiary information you need to do nothing. Please check your Personal Information to make sure it is correct as well.**

## Your Personal Information

Below is your personal information that is currently on file. Please review this information to verify that it is accurate and complete. If your home address or telephone number is wrong or has recently changed, you may update the information online when you enroll or when you meet with a Benefit Counselor.

**Home Address:** [redacted] **Birth Date:** [redacted]

**Home Telephone:** **Hire Date:** 7/27/1998

## Your Covered Dependents

Following is a list of dependents currently on file for you. Please verify that the information shown below is correct and complete.

| Dependent Name | Relationship | Birth Date | Sex | Med | Dent | Vis |
|---|---|---|---|---|---|---|
| [redacted] | Spouse | [redacted] | M | N | N | N |
| [redacted] | Child | [redacted] | F | N | N | N |
| [redacted] | Child | [redacted] | M | N | N | N |

## Your Beneficiary Information

Following is the beneficiary information currently on file. Please verify that the information shown below is correct and complete. If you do not have any beneficiaries listed or if your beneficiary information is not correct, please log on the enrollment website and update your beneficiary information.

| Plan | Beneficiary Name | Relationship | Beneficiary Type | Percentage |
|---|---|---|---|---|
| Basic Life & AD&D | [redacted] | Spouse | Primary | 100.00% |
| Basic Life & AD&D | [redacted] | Child | Contingent | 50.00% |
| Basic Life & AD&D | [redacted] | Child | Contingent | 50.00% |

Dept # Human Resources

City of Asheboro
225 E. Academy Street
Asheboro NC 27203

**The Lincoln National Life Insurance Company,** PO Box 2649, Omaha, NE 68103-2649
toll free (800) 423-2765 Fax (800) 462-4660
www.LincolnFinancial.com

### BENEFICIARY DESIGNATION FORM

| Policyholder/Employer | Policy Number(s) |
|---|---|
| Employee Name | Employee Social Security or Certificate Number |
| Employee Address (Street, City, State) | Employee Telephone Number |

**WHO ARE YOUR BENEFICIARIES?**

It is very important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). If multiple primary beneficiaries or contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. If more space is needed to list your beneficiaries please attach a sheet to this form. **The beneficiary(ies) named on this form will be valid for all basic, optional, and/or voluntary group term life and AD&D coverages unless otherwise indicated by you. The beneficiary designation may not go into effect until this form is signed and dated by you. Page 2 of this form includes examples of how to complete this form.**

**PRIMARY BENEFICIARY(IES)**

| Primary Beneficiary's Name and Address | Social Security Number | Relationship to You | Date of Birth | Percentage: Must equal 100% |
|---|---|---|---|---|
| Name:<br>Address: | | | | |
| Name:<br>Address: | | | | |
| Name:<br>Address: | | | | |

**CONTINGENT BENEFICIARY(IES):** Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

| Contingent Beneficiary's Name and Address | Social Security Number | Relationship to You | Date of Birth | Percentage: Must equal 100% |
|---|---|---|---|---|
| Name:<br>Address: | | | | |
| Name:<br>Address: | | | | |
| Name:<br>Address: | | | | |

**Community Property State Consent for residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.** If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

Signature of Spouse ______________________ Date ____________

**Signature of Employee** ______________________ **Date** ____________



UNITED STATES POSTAGE PITNEY BOWES
$ 000.50
02 1P 0008899881 MAILED FROM ZIP CODE 27203

City of Asheboro
Human Resources Department
225 East Academy Street
Asheboro, N.C. 27203

City of Asheboro
Human Resources Department
225 East Academy Street
Asheboro, N.C. 27203