

VISION INSURANCE ENROLLMENT/CHANGE FORM

CITY OF MILWAUKEE

A SUBSCRIBER INFORMATION						
LAST NAME	FIRST NAME	M.I.	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH / /	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
HOME ADDRESS			CITY	STATE	ZIP CODE	PHONE NUMBER
COVERAGE TYPE Single <input type="checkbox"/> EE+Spouse <input type="checkbox"/> EE+Dep <input type="checkbox"/> Family <input type="checkbox"/>				6 DIGIT EMPLOYEE ID (REQUIRED)		CITY START DATE / /

B REASON FOR SUBMITTING ENROLLMENT/CHANGE FORM (MUST SELECT ONE OPTION AND ENTER DATE)	
<input type="checkbox"/> INITIAL ENROLLMENT <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> RETURN TO WORK <input type="checkbox"/> MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> NAME CHANGE From: _____ To: _____ <input type="checkbox"/> ADD/REMOVE SPOUSE/DEPENDENT <input type="checkbox"/> DEATH <input type="checkbox"/> OTHER _____	REQUIRED Date of Change: / /

C FAMILY COVERAGE -- LIST ALL INDIVIDUALS TO INCLUDE/ADD/REMOVE ON VISION INSURANCE PLAN						
LAST NAME	FIRST NAME	M.I.	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH / /	RELATIONSHIP	Action Requested
			M <input type="checkbox"/> F <input type="checkbox"/>	/ /		<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT
			M <input type="checkbox"/> F <input type="checkbox"/>	/ /		<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT
			M <input type="checkbox"/> F <input type="checkbox"/>	/ /		<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT
			M <input type="checkbox"/> F <input type="checkbox"/>	/ /		<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT
			M <input type="checkbox"/> F <input type="checkbox"/>	/ /		<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT
			M <input type="checkbox"/> F <input type="checkbox"/>	/ /		<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT

D IF ENROLLING DEPENDENTS, SUBSCRIBER MUST COMPLETE THE FOLLOWING INFORMATION.
Is any unmarried dependent child over the age of 26 on this form unable to be self-supporting due to a mental or physical handicap or disability? YES <input type="checkbox"/> NO <input type="checkbox"/> If Yes, please indicate name: _____

E SIGNATURE BLOCK (This application is not valid without being signed and dated.)*
I apply for enrollment under the terms and conditions of my employer's Vision Plan as administered by the entity stated in Section A and subject to the coverage rules and conditions on the reverse side. I understand that coverage is not effective until I have satisfied the Vision plan coverage eligibility criteria and rules. I authorize any payroll deductions that may be necessary to cover the cost of my plan. To the best of my knowledge, all statements and answers in this application are complete and true and that any misrepresentation of coverage in this application may result in loss or denial of coverage for me and my dependents.
X _____ / / <div style="display: flex; justify-content: space-between;"> SUBSCRIBER SIGNATURE DATE SIGNED </div>

*I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature and typed signature in a fillable form or typed signature via Adobe Pro.

Active Employees: Return completed form to DER Employee Benefits City Hall, Room 706 or derbenefits@milwaukee.gov

Terms and Conditions

- To the best of my knowledge, all statements and answers on this enrollment form are complete and true and any misrepresentation of coverage in this application may result in loss or denial of coverage for me and my dependents.
- I authorize the City of Milwaukee to deduct from my wages or salary an amount sufficient to provide for regular vision premium payments that are not otherwise contributed by the City.
- I acknowledge that children listed on this enrollment form identified as “dependent” are under age 26 and eligible for coverage as measured by standards employed by the IRS for determining dependency. Any child listed as a dependent who is over the age of 26 must be disabled so as to be incapable of self-support in order to remain eligible for coverage.

Notice to Members Regarding the Thirty-One Day Rule for Vision Plan Coverage

City of Milwaukee employees are responsible for keeping their enrollment status current and notifying the DER Employee Benefits Division within 31 days of births, adoptions, marriages (including marriage to another City employee), divorces, changes in dependent eligibility status, deaths and Medicare coverage. Coverage for dependents is effective the date of the family status change provided members notify DER within 31 days of the event. Members must submit a copy of the marriage certificate, birth certificate for each dependent enrolling in benefits. Non-compliance with coverage eligibility rules may expose members to additional costs or result in removal of dependents from the plan. There are no exceptions to this rule.

Enrollment Status and Changes

- City employees must use the City’s Self Service program www.milwaukee.gov/selfservice to make changes or updates to their enrollment status including address changes, births, adoptions and marriages. Employees must have their Employee ID number (6 digits) and a password to access self service. To request or reset a password visit www.milwaukee.gov/rits.
- City employees must fill out a paper enrollment form for any other status changes, such as divorce or removal of dependents.
- City employees returning to work must complete a vision enrollment form within 31 days of their return to work date.
- Agency employees must complete a vision enrollment form within 31 days of their start date and notify the appropriate agency of any other enrollment status changes within 31 days of the event.

Compliance Notifications

Important legal notices, including HIPPA notice of privacy practices, affecting employee vision plans are posted on DER’s benefits website. Visit www.milwaukee.gov/DER and go to the Benefits tab and select “L” which will take you to the Legal Notices link.