



**City of Niceville  
Benefits Election/Change Form  
10/01/2025 – 09/30/2026**



**Please select the reason for benefit enrollment or change (select all that apply).**

<b>Enrollment Type:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Rehire <input type="checkbox"/> Qualifying Life Event  Effective Date: _____	<b>Change Type:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change  Date of Change: _____	<b>Reason for Change:</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Coverage
--	--	---

**Section 1: Employee Information (all employees must complete this section, even if waiving coverages)**

<b>Employee Name:</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth (mm/dd/yyyy):</b>
<b>Street Address:</b>		<b>Social Security Number:</b>	<b>Job Title:</b>
<b>City, State, Zip Code:</b>		<b>Full-Time Date of Hire (mm/dd/yyyy):</b>	<b>Salary:</b> <input type="checkbox"/> Annual: \$ _____ <input type="checkbox"/> Hourly Rate: \$ _____ (if applicable)
<b>Phone Number:</b>	<b>Email Address:</b>	<b>Pay Basis:</b> <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	

**Section 2: Dependent Information (please complete if enrolling in coverage)**

Name	Relationship	Date of Birth	Gender	Social Security #
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	

**Section 3: 100% Employer Sponsored Coverage(s), at no cost to you!**

<b>X Basic Life and AD&amp;D</b>	United Healthcare – 2 x earnings up to \$150,000
----------------------------------	--

Please indicate your selection(s) with "X" for each benefit, whether electing or declining coverage.

**Section 4: Medical – United Healthcare**

Weekly Deductions	Employee (EE) Only	EE + Family		
<b>Plan 1 EKM2</b>	<input type="checkbox"/> \$54.35	<input type="checkbox"/> \$350.62		
<b>Plan 2 EKMY</b>	<input type="checkbox"/> \$27.12	<input type="checkbox"/> \$263.47		
<b>Plan 3 EKRF</b>	<input type="checkbox"/> \$ 0.00	<input type="checkbox"/> \$176.71		
<b>Plan 4 EKR5</b>	<input type="checkbox"/> \$19.73	<input type="checkbox"/> \$239.20		
<b>Waive Coverage</b>	<input type="checkbox"/> I Decline Medical Coverage			
Reason for Declining Coverage: <input type="checkbox"/> Spousal <input type="checkbox"/> Parental <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> VA <input type="checkbox"/> Individual Plan <input type="checkbox"/> Cost/Don't Want				

**Section 5: Dental – Humana**

Weekly Deductions	Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
<b>Dental PPO</b>	<input type="checkbox"/> \$ 5.92	<input type="checkbox"/> \$13.00	<input type="checkbox"/> \$14.77	<input type="checkbox"/> \$23.26
<b>Waive Coverage</b>	<input type="checkbox"/> I Decline Dental Coverage			

**Section 6: Vision – Humana**

Weekly Deductions	Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
<b>Humana Vision</b>	<input type="checkbox"/> \$ 1.30	<input type="checkbox"/> \$ 2.59	<input type="checkbox"/> \$ 2.93	<input type="checkbox"/> \$ 4.33
<b>Waive Coverage</b>	<input type="checkbox"/> I Decline Vision Coverage			

\*\*\*\* Please add dependent information in Section 2 if enrolling in coverage \*\*\*\*



**City of Niceville  
Benefits Election/Change Form  
10/01/2025 – 09/30/2026**



**Section 7a: Employee Supplemental Life/AD&D -UHC**

<i>Weekly Deductions</i>	
Employee	<input type="checkbox"/> See Rate Sheet
Waive Coverage	<input type="checkbox"/> I Decline Employee Supplemental Life/AD&D Coverage

**Section 7b: Spouse Supplemental Life - UHC**

<i>Weekly Deductions</i>	
Spouse ( <i>enter spouse info in Sect 2</i> )	<input type="checkbox"/> See Rate Sheet
Waive Coverage	<input type="checkbox"/> I Decline Spouse Supplemental Life/AD&D Coverage

**Section 7c: Child Supplemental Life - UHC**

<i>Weekly Deductions</i>	
Child ( <i>enter child(ren) info in Sect 2</i> )	<input type="checkbox"/> See Rate Sheet
Waive Coverage	<input type="checkbox"/> I Decline Child Supplemental Life/AD&D Coverage

\*\*\*\* Please add dependent information in Section 2 if applying for spouse and/or child life coverage \*\*\*\*

**Section 8a: Short Term Disability - UHC**

<i>Weekly Deductions</i>	
Employee	<input type="checkbox"/> See Rate Sheet
Waive Coverage	<input type="checkbox"/> I Decline Short Term Disability

**Section 8b: Long Term Disability - UHC**

<i>Weekly Deductions</i>	
Employee	<input type="checkbox"/> See Rate Sheet
Waive Coverage	<input type="checkbox"/> I Decline Long Term Disability

**Section 9a: Critical Illness - UHC**

<i>Weekly Deductions</i>	Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
Option A	<input type="checkbox"/> See Rate Sheet	<input type="checkbox"/> See Rate Sheet	<input type="checkbox"/> See Rate Sheet	<input type="checkbox"/> See Rate Sheet
Option B	<input type="checkbox"/> See Rate Sheet	<input type="checkbox"/> See Rate Sheet	<input type="checkbox"/> \$ See Rate Sheet	<input type="checkbox"/> See Rate Sheet
Waive Coverage	<input type="checkbox"/> I Decline Critical Illness			

**Section 9b: Accident Plan- UHC**

<i>Weekly Deductions</i>	Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
Option 1	<input type="checkbox"/> \$ 1.83	<input type="checkbox"/> \$ 2.92	<input type="checkbox"/> \$ 4.29	<input type="checkbox"/> \$ 6.41
Option 2	<input type="checkbox"/> \$ 2.40	<input type="checkbox"/> \$ 3.82	<input type="checkbox"/> \$ 5.66	<input type="checkbox"/> \$ 8.45
Waive Coverage	<input type="checkbox"/> I Decline Accident			

**Section 9c: Hospital Indemnity - UHC**

<i>Weekly Deductions</i>	Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
Option A	<input type="checkbox"/> \$ 2.48	<input type="checkbox"/> \$ 5.97	<input type="checkbox"/> \$ 4.68	<input type="checkbox"/> \$ 8.70
Option B	<input type="checkbox"/> \$ 3.47	<input type="checkbox"/> \$ 8.41	<input type="checkbox"/> \$ 6.63	<input type="checkbox"/> \$ 12.35
Waive Coverage	<input type="checkbox"/> I Decline Hospital Indemnity			



City of Niceville  
Benefits Election/Change Form  
10/01/2025 – 09/30/2026



**Section x: Beneficiary Information**

	Name	Relationship	Phone #	Date of Birth	Benefit %
Primary Beneficiary #1					
Primary Beneficiary #2					
Contingent Beneficiary #1					
Contingent Beneficiary #2					

If you wish to designate additional beneficiaries, or you would like to designate different beneficiaries between Basic & Vol Life, please attach a separate sheet of paper.

**Section x: Employee Agreement and Acknowledgement:**

*Please read the following agreement and sign below:*

I authorize my employer to deduct from my earnings the amount required to cover my share of the premiums for the selected coverage(s).

\_\_\_\_\_  
**Employee Signature** (please sign, do not print name)

\_\_\_\_\_  
**Date**