

Name: Last FEMALE MALE First MI Employee ID Number:
 Street Address: Phone Number:
 City: State: Zip: Email:

CORE COVERAGE OPTIONS AND MONTHLY RATES

| | | | | | | |
|----------------|---------|---------|-------|--------------------------------|-------------------------------------|----------------------------------|
| Health: | DECLINE | PREMIER | VALUE | EMPLOYEE (V=\$0.00 P=\$0.00) | EMPLOYEE+1 (V=\$34.67 P=\$227.50) | FAMILY (V=\$101.83 P=\$361.83) |
| Dental: | DECLINE | PREMIER | VALUE | EMPLOYEE (V=\$0.00 P=\$6.80) | EMPLOYEE+1 (V=\$3.70 P=\$26.65) | FAMILY (V=\$5.36 P=\$41.29) |
| Vision: | DECLINE | | | EMPLOYEE (\$4.58) | EMPLOYEE+1 (\$9.21) | FAMILY (\$14.82) |

Premiums will be collected on a monthly basis. October 2020 premiums will be deducted from your final paycheck.

Please also deduct my November 2020 and December 2020 premiums from my final paycheck.

DEPENDENT(S) Supporting documentation is required for new dependents.

COVERAGE

| Name (Last, First, Middle Initial) | Sex | Relationship | Social Security # | Date of Birth | Health | | Dental | | Vision | |
|------------------------------------|-----|--------------|-------------------|---------------|--------|------|--------|------|--------|------|
| | | | | | ADD | DROP | ADD | DROP | ADD | DROP |

VOLUNTARY BENEFITS

Do you have Unum Products? Yes No

Do you have Boston Mutual Products? Yes No

My spouse is/was a City of Birmingham employee. | SPOUSE'S LEGAL NAME:

I authorize the City of Birmingham to take deductions from my earnings for the benefit(s) selected above.
 I understand that these elections cannot be changed during the plan year unless I submit supporting documentation within thirty (30) days of a qualifying event.

Signature:

Date: