City of Houston Benefits Eligibility Processing Form

611 Walker, 4th Floor, Houston, TX 77002 | 832-393-6000 | 832-395-9409
benefits@houstontx.gov | cityofhoustonbenefits.org

To add or remove yourself and/or dependent(s) on your benefits coverage, **submit this form with the appropriate documentation within 30 days of your date of hire or 31 days of your qualifying life event**. If you do not submit these documents timely, your benefit elections will not be processed. The next opportunity to process elections will be during the next Open Enrollment.

Fax, email, mail or deliver this form, along with the supporting documents to the Human Resources Benefits Division:

832-395-9409
benefits@houstontx.gov
611 Walker St, 4th Floor, Houston, TX 77002

Total Number of pages):_____ **Date of Hire or Qualifying Event:**_____

Employee Name	Employee ID	Contact Number	Email

Address	City	State	Zip

Triggering event: Check the appropriate option below.

☐ New Employee ☐ Open Enrollment ☐ Qualifying Event

Requested Action: Check the appropriate option below.

☐ Coverage Termination ☐ Coverage Enrollment

Benefit(s) Impacted: Check all that apply.

☐ **Medical** (Select a plan)
- ☐ Open Access Plan
- ☐ CDHP
- ☐ Limited Network (Select a physician's network)
  - ☐ Kelsey-Seybold
  - ☐ Renaissance - Physician ID _____
  - ☐ Village Family Practice - Physician ID _____

☐ **Dental** (Select a plan)
- ☐ DHMO
- ☐ DPPO

☐ **Vision**

Employee or Dependents Impacted: Complete for all applicable.

First Name	Middle Initial	Last Name	Date of Birth	Social Security No.	Relationship	Add to Medical	Add to Dental	Add to Vision	Tobacco User*
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐

***Non-tobacco User Discount -** If you and/or your dependents do not use tobacco products, you qualify for the monthly non-tobacco user discount of $35 per non-tobacco user. If you and/or any of your dependents indicated tobacco use, you will not be eligible for the non-tobacco user discount. By enrolling and participating in a smoking/tobacco cessation program, you may become eligible for the monthly non-tobacco user discount of $35 per participant. In order to be eligible for the discount, previously indicated tobacco users on the medical plan must participate in a smoking cessation program. Smoking/tobacco cessation programs must be facilitated or validated by the City of Houston.

Required Supporting Documents to Add Dependent Coverage

All necessary documents as identified below must be submitted and verified before dependents can be covered under any City of Houston benefits plans. Some of the submitted documents must be County Clerk certified or court-filed documents. Each submitted document will be reviewed by the Benefits Division for approval before processing changes to coverage.

Legal Spouse	Biological Children (under age 26)	Stepchildren (under age 26)	Biological Grandchildren* (under age 25)	Adopted/Court Ordered Dependents
☐ Social Security Card ☐ Marriage Certificate (front) ☐ Marriage Certificate (back) **OR** ☐ Social Security Card ☐ Declaration of Registration of Informal Marriage (Common Law)	☐ Social Security Card ☐ Birth Certificate **OR** ☐ Social Security Card ☐ Verification of Birth Facts	☐ Social Security Card ☐ Birth Certificate ☐ Marriage Certificate (front) ☐ Marriage Certificate (back)	☐ Social Security Card ☐ Birth Certificate ☐ Current IRS Filing ☐ Birth Certificate of Grandchild ☐ Birth Certificate of Grandchild's Natural Parent/ Employee's Biological Child ***step-grandchildren are not eligible for coverage**	☐ Social Security Card ☐ Adoption/Guardianship Documents ☐ Birth Certificate **OR** ☐ Social Security Card ☐ Custody/Court Order Documents ☐ Birth Certificate

Note: Eligible Dependent - An eligible dependent is your legal spouse and any child (natural, adopted, foster, grandchild, stepchild, and a child for whom you are legal guardian and/or have legal support obligation) who is your dependent for federal income tax purposes, resides with you, and is under age 26 or under age 25 for grandchild(ren).

Disabled children age 26 and over - Child must be primarily supported by you, and incapable of self-sustaining employment by reason of mental incapacity, physical disability or handicap, which arose while the child was covered as a dependent on a city plan without a break in coverage. Upon applying and receiving third party medical administrator's approval, proof of the child's condition and dependence must be submitted within 31 days or the child ceases to qualify for benefits.

Important - If both you and your spouse work(ed) for the city, you may be covered as an employee/retiree or as a dependent - but not both. Dependents may be enrolled under only one parent or guardian.

Supporting Documents Required to Change Coverage as a Result of a Qualifying Event

Newborn	Marriage	Divorce	Lost or Obtained Medical Coverage
☐ Verification of Birth Facts (within 31 days) ☐ Social Security Card (within 60 days)	☐ Marriage Certificate (front) ☐ Marriage Certificate (back) ☐ Social Security Card	☐ Copy of Divorce Decree	☐ Letter of Creditable Coverage

Drop Child/Grandchild/ Stepchild Over 18	Drop Ineligible Dependent	Return from Military Service
☐ No support needed	☐ No support needed	☐ No support needed

I hereby certify that the dependent(s) listed above is/are my dependent(s) as defined by the Internal Revenue Service and as defined in the City of Houston Health Benefits plans. I further certify that the information and all supporting documentation submitted with this application or in the future in connection herewith is true and correct. Any misrepresentation (overt or by omission) may be considered a fraudulent act. Therefore, any fraudulent act or refusal to provide the documentation required shall be grounds for denial of coverage or refusal or rescission of coverage applicable to the dependent(s) for whom the misrepresentation relates. Neither, the insurance carrier, the City of Houston or the plan administrator will have further liability or obligation to cover the expenses of such dependent(s). The City of Houston or carrier would also be entitled to recover any expenses incurred and improperly paid by it by reason of such misrepresentation. This certification is made under penalty of perjury for the consideration and purpose of obtaining benefits for said dependent(s) designated on this form.

Employee Authorization of Payroll Deductions

I am an employee of the City of Houston, eligible to participate in the medical and dental and vision program. I apply to participate and understand that the information I have provided above is part of my application. All statements made by me may be relied upon by the city. If any information that I have provided is found to be materially incorrect, my coverage may be denied. I realize that any medical coverage I or my dependents are eligible for at this time, which I decline, may be available in the future if I provide proof of a change in family status within 31 days of family status change.

I agree that if I have listed ineligible dependents, my medical coverage may be cancelled. I authorize the City of Houston to deduct from my wages or salary my portion of the contribution as it becomes due. I understand that I must notify the City of Houston when I have an ineligible dependent, and that I may receive a refund of premiums paid for an ineligible dependent for up to two months. I will be responsible for any and all medical, dental and vision claims paid on an ineligible dependent.

Print Employee Name: _____ Employee Signature: _____

Date: _____ Employee ID#: _____

For Internal Use Only

Received by: _____ Processed by: _____ QC Review by: _____

Date: _____ Date: _____ Date: _____