CITY OF NEWPORT BEACH
Box 1768
Newport Beach, CA 92658-8915

HEALTH PLAN BENEFITS
ACTIVE EMPLOYEE
EMPLOYEE ELECTION FORM

Name:	**Social Security Number:**
Street Address:	**Work Phone Number:**
City, State, Zip Code:	**Home Phone Number:**
Email Address:	**Date of Birth:**
Department:	**Date of Hire:**

This sheet is used to select the employee health benefit options for which you are eligible as a City of Newport Beach Employee. **If enrolling, you must also complete the enrollment applications required by the insurance carrier.** These forms are included in the enrollment packet.

HEALTH BENEFIT PLAN OPTIONS

For the 2025 plan year, the City's contribution varies depending upon your bargaining unit.

Fill In Plan Selected, Check Appropriate Status for Each Line of Coverage

Medical
My Plan Choice is:

_____

Single	Two-Party	Family	Coverage Declined
[ ]	[ ]	[ ]	[ ]

(If choosing the Opt Out Program, proof of other group insurance is required.)

Dental
My Dental Plan Choice is:
[ ] Delta Dental DHMO
[ ] Delta Dental PPO

Single	Two Party	Family	Coverage Declined
[ ]	[ ]	[ ]	[ ]

Vision
Check Appropriate Box:
[ ] VSP Vision PPO

Single	Two Party	Family	Coverage Declined
[ ]	[ ]	[ ]	[ ]

(BENEFIT INFORMATION CONTINUES ON THE REVERSE SIDE OF THIS FORM)

VOLUNTARY FLEXIBLE SPENDING ACCOUNTS

Health Care Flexible Spending Account (FSA)

The Health Care Flexible Spending Account offers you a means of obtaining **pre-tax reimbursement** for eligible medical, dental and vision care expenses that are not covered by your health insurance plans. Contributions to this account must be used to pay for related services received during the 2025 plan year. Claims for the 2024 plan year must be received by the FSA administrator no later than March 28, 2025. Any money remaining in your account between $600 and $50 may be rolled into the next plan year. Amounts remaining in your account that over $600 and under $50 after March 28, 2025, will be forfeited.

My Annual Health Care Account Election Amount (minimum of $130, maximum of $3,200 annually); if declining please put 0. If electing, please complete the FSA Enrollment Form.	$

Dependent Care Flexible Spending Account (FSA)

The Dependent Care Flexible Spending Account offers you a means of obtaining **pre-tax reimbursement** for dependent care expenses for a child or an elder you incur on eligible dependents. This dependent care expense is only covered if the expense allows you (and your spouse, if applicable) to continue working. Contributions to this account must be used to pay for dependent care expenses incurred during the 2025 plan year. Claims for the 2024 plan year must be received by the FSA administrator no later than March 28, 2025. Amounts remaining in your account after March 28, 2025, will be forfeited.

My Annual Dependent Care Account Election Amount (minimum of $1,000, maximum of $5,000 annually, if married filing jointly or a single parent. Married participants filing separately are limited to $2,500 annually); if declining please put 0. If electing, please complete the FSA Enrollment Form.	$

ACKNOWLEDGMENT SECTION

1. I understand that I cannot change my health plan elections or my flexible spending account elections (if applicable) until the next annual open enrollment period unless I have an eligible qualifying event or change in family status.

2. I understand that I must advise Human Resources, accompanied by the appropriate documentation, of any dependents that become ineligible as a result of divorce or exceeding the age limitation of the plan within 60 days of their change in status. I understand that failure to report ineligible dependents may result in the loss of their COBRA continuation rights. In addition, I may be responsible for premiums and claim expenses paid on behalf of ineligible dependents.

3. I understand that I must advise Human Resources, accompanied by the appropriate documentation, of any new dependents as the result of birth, adoption or placement for adoption, marriage, or a change in a spouse's employment, within 60 days of the event. Failure to provide notification will result in the dependent losing eligibility for coverage until the next open enrollment.

Date _____ Employee Signature _____

Your enrollment will not be finalized until the enrollment forms are submitted and accepted by the insurance carrier. Failure to complete the required forms will void any elections you make.