Employee Medical, Dental & Vision Election Change Form - 2026

Return to Rachel at rachel@peoriagov.org, fax 309-494-8587 or drop off at City Hall, Suite 200

SUBSCRIBER INFORMATION

Name (Last, First, MI)	Social Security Number	Gender

Physical Address	City	State	Zip Code

Mailing Address, *if different from above*	City	State	Zip Code

Phone:	eMail:	Birthdate:

Marital Status: ☐ Single   ☐ Married   ☐ Divorced   ☐ Widowed

QUALIFIC EVENT DATE: _____ CHANGE FORM MUST BE SUBMITTED WITH PROOF OF THE EVENT WITHIN 31 DAYS OF THE EVENT

WHAT IS THE QUALIFYING EVENT: *(MUST PROVIDE SUPPORTING DOCUMENTATION)*

☐ NEW HIRE   ☐ MARRIAGE   ☐ ELIGIBILITY OF OTHER COVERAGE

☐ BIRTH/ADOPTION   ☐ QUALIFYING EVENT – ADD DEPENDENT   ☐ LOSS OF OTHER COVERAGE

☐ DIVORCE   ☐ QUALIFYING EVENT – TERMINATE COVERAGE ☐ DEATH

NEW 2026 ELECTION: *You cannot switch from high deductible to low deductible or low deductible to high deductible mid-year.*

MEDICAL PLAN	MEDICAL COVERAGE	DENTAL COVERAGE	VISION COVERAGE
☐ Low Deductible	☐ Member Only	☐ Member Only	☐ Member Only
☐ High Deductible	☐ Member + Partner	☐ Member + Partner	☐ Member + Partner
☐ Waive Coverage	☐ Member + Child(ren)	☐ Member + Child(ren)	☐ Member + Child(ren)
	☐ Member + Family	☐ Member + Family	☐ Member + Family
		☐ Waive Coverage	☐ Waive Coverage

DEPENDENT INFORMATION *NEED A BIRTH CERTIFICATE (CHILDREN) OR A MARRIAGE CERTIFICATE/AFFIDAVIT (SPOUSE/DOMESTIC PARTNER) FOR ANYONE LISTED BELOW*

Name (Last, First, MI)	Relationship	Gender	Date of Birth	S.S. Number	Enroll in Medical	Enroll in Dental	Enroll in Vision
					☐	☐	☐
					☐	☐	☐

FSA FOR HEALTH CARE ELECTION (only available to City or Library Employees Participating in the **LOW-DEDUCTIBLE PPO**):

☐ Please deduct $_____ PER PAY PERIOD to be deposited into my Health Care FSA (not available to Township/Assessor).
Minimum annual contribution is $100; Maximum is $3,400. Contribution amount cannot be changed mid-year without a qualifying event.

☐ I choose not to participate in the FSA program.

HSA (HEALTH SAVINGS ACCOUNT) ELECTION (only available to City or Library Employees Participating in the **HIGH-DEDUCTIBLE PPO**):

☐ Please deduct $_____ PER PAY PERIOD to be deposited into my HSA (not available to Township/Assessor).
Minimum annual contribution is $100; Maximum for City employees is $3,900/member only or $8,250/other coverages. Maximum for Library employees is $4,400/member only or $8,750/other coverages. Members age 55 or older may contribute an additional $1,000. This contribution amount may be changed at any time within the plan year.

☐ I choose not to make additional contributions to the HSA program at this time.

FSA FOR DEPENDENT CARE (available to City or Library Employees):

☐ Please deduct $_____ PER PAY PERIOD to be deposited into my Dependent Care FSA (not available to Township/Assessor).
Minimum annual contribution is $100; Maximum is $7,500. Contribution cannot be changed mid-year without a qualifying event.

COORDINATION OF BENEFITS   Are you or any dependents listed above covered by another insurance plan?   ☐ NO   ☐ YES
(If Yes, provide copy of insurance card to UMR by calling 1-800-826-9781)

Signature_____   Date_____

I certify this information is complete and accurate to the best of my knowledge. I understand any false statements could result in the termination of coverage for me and/or any dependents. I understand changes to this election can only be made during annual open enrollment; or mid-year in conjunction with a Qualifying Event which must be provided in writing to the benefits department within 31 days of the date of the event.

Office Use Only: Start Date: _____   Location: _____