AFFIRMATIVE ELECTION FORM 2021

FAILURE TO COMPLETE AND RETURN THIS FORM BY DECEMBER 1, 2020 WILL RESULT IN A CHANGE TO YOUR HEALTH BENEFITS ELECTION.

EMPLOYEE INFORMATION **Please PRINT**		
Last Name	**First Name**	**SSN**
E-mail:	**Date of Birth:**	

I understand by signing this form, I choose to keep my current health benefits election (enrolled or waived) for 2021. I also understand that I am not permitted to make any changes to my health benefits election until the next open enrollment period, unless I have a qualifying life event.

If you experience a qualifying life event and need to change your health benefits election, please contact the Benefits Manager within 30 days of the event. Examples of a qualifying event include:

- Marriage
- Birth or adoption of a child
- Death of a covered dependent
- Divorce
- Loss or reduction of coverage for you or your spouse

Employee Signature

_____

Date

_____

Return completed form to K. Mangum-Ross, Benefits Manager, Human Resources Department