

CITY OF ST. LOUIS
DEPARTMENT OF PERSONNEL

ORIGINAL

CHANGE

DATE

EMPLOYED _____

CONSOLIDATED ENROLLMENT AND PAYROLL DEDUCTION AUTHORIZATION FORM

SECTION I: General Information

1. Name _____ 2. Soc. Sec.# _____
(Last) (First) (MI)
3. Address _____ 4. Date of Birth _____
(Number & Street) (City) (State) (Zip) (Mo) (Day) (Yr)
5. Sex Male ___ Female ___ 6. Single ___ Married ___ Other ___ 7. Dept. No. _____

SECTION II: Medical Insurance

Effective Date _____

8. Employee Medical: Employee cost is paid up to an amount determined by the City. **Complete the proper enrollment form.***
9. Dependent Medical: Yes ___ No ___ (If dependent child is over age 19, submit qualifying proof of status as full-time student or total disability. If adding domestic partner, Affidavit of Domestic Partnership must be submitted with enrollment form.)
10. Is spouse/domestic partner a City employee? Yes ___ No ___ 11. Is s/he covered by the same Medical Plan? Yes ___ No ___
12. If Yes: Spouse/Domestic Partner Name _____ Dept. _____

SECTION III: Optional Benefits

Coverage is dependent on fulfilling carrier eligibility requirements and completing proper forms.

(If adding domestic partner, Affidavit of Domestic Partnership must be submitted with enrollment form.)

Dental Coverage*

Dental Source 800-369-3485
Free Access Plan
"E" Plan

United Concordia 314-205-9605

Legal Coverage

Hyatt Legal 800-821-6400

Contact Provider For Additional Information on Optional Benefits Listed Below

Cancer/Intensive Care and Accident Expense Benefits

AFLAC 636-227-4670
Conseco 800-628-6428 (Domestic partner coverage not available)

Deferred Compensation 800-701-8255 or 314-241-1334

* Available on a **BEFORE-TAX** or **AFTER-TAX** basis.

