FHCSD
Wellness

MY BENEFICIARY will be…

You may add up to 10 primary beneficiaries

First Name: _____

Last Name: _____

Relationship: _____

Phone #: _____

Address: _____

_____

SSN #(Optional): _____

QUESTIONS I will bring to DAY ONE

_____

_____

_____

_____

_____

_____

Still Have Questions? Call the My Benefit Champion Line at 1(877)679-2011 (or ext. 4200 from any FHCSD phone line) or email champion@hubinternational.com

BENEFIT PRE-ELECTION AND BENEFICIARY FORM

Review your eligibility, plans, enrollment deadlines, and other information on the Benefits and Wellness Website and Come Prepared to enroll DAY ONE

CHOOSE YOUR MEDICAL, DENTAL, VISION

My MEDICAL plan will be SELECT ONE

for SELECT ONE

My DENTAL plan will be SELECT ONE

for SELECT ONE

My VISION plan will be SELECT ONE

for SELECT ONE

CHOOSE YOUR PRIMARY CARE PHYSICIAN (CIGNA PLAN MEMBERS ONLY)

Name: _____

PCP Code: _____

Find PCP code at www.cigna.com, review PCP Guide for instructions

FLEXIBLE SPENDING ACCOUNTS

HealthCare FSA Annual Amount: $_____

Dependent Care FSA Annual Amount: $_____

VOLUNTARY UNUM BENEFITS

Supplemental Life Insurance (Employee Only): $_____

Supplemental Life Insurance (Spouse): $_____

Supplemental Life Insurance (Child): $_____

LTD Buy Up: SELECT ONE

Accident Plan: SELECT ONE

Hospital Plan: SELECT ONE

Critical Illness Plan: SELECT ONE

Disability Plan: SELECT ONE