



Acknowledgment of Notices

Today's Date: ____/____/____

First Day of employment: ____/____/____

Name: _____

ID#: _____

By my signature below, I understand that if I do not enroll in benefits within 30 days from the first day of employment, I will NOT have benefits through the City of Carrollton and the next time for me to enroll would be during the annual open enrollment period. I acknowledge that I will not be updated with the insurance carriers until I have made my elections. I understand that I must provide proof of dependent status for my dependents to be covered and that if I do not provide proof of dependent status when I enroll in coverage, or within thirty days of my first day of employment, my dependents will not be covered.

I understand that once I enroll in medical and dental coverage, the Health Care or Dependent Care Flexible Spending Accounts or the supplemental life or dependent life insurance, my coverage will go into effect retroactively to my date of hire and I will owe any back premiums for my coverage retroactive to the effective date. I understand my vision election will go into effect the first of the month following my date of hire and I will owe any back premiums for my vision coverage retroactive to the effective date.

Signature of Employee: _____

Date: _____

By my signature below, I acknowledge that I have been given access to the following: **Notice of Special Enrollment Opportunities, Women's Health and Cancer Rights**, and the **Initial HIPPA Notice**.

Signature of Employee: _____

Date: _____

By my signature below, I certify that I have received **Form SSA – 1945** that contains information about the possible effects of the **Windfall Elimination Provision and the Government Pension Offset Provision** on my potential future Social Security benefits.

Signature of Employee: _____

Date: _____