Internal Use Only

Wellness For Life
Benefits Election Form

EMPLOYEE INFORMATION

Last Name	First Name	Employee ID
Division/Department	Phone Number	Email Address

Rehires Only *(check if applicable)* Are you currently receiving a medical Health Insurance Subsidy?

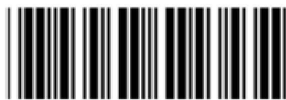
ENROLLMENT TYPE *(select one)*: ☐ New Hire ☐ Open Enrollment ☐ Qualified Event ____________________

(Bi-Weekly rates listed in Benefits Handbook) **EVENT DATE:** ____________ **EFFECTIVE DATE:** ____________

MEDICAL	Action	__ No Change	__ Elect Coverage	__ Waive Coverage	__ Add/Remove Dependents
	Dependent	__ EE Only	__ EE + SP	__ EE + CH	__ EE + Family
	Plan Option	__ OrangePrime Plus (HDHP)		__ OrangePrime (LDHP)	__TRICARE Supplement
DENTAL	Action	__ No Change	__ Elect Coverage	__ Waive Coverage	__ Add/Remove Dependents
	Dependent	__ EE Only	__ EE + 1	__ EE + 2 or more	
	Plan Option	__ Low Plan	__ Middle Plan	__ High Plan	
VISION	Action	__ No Change	__ Elect Coverage	__ Waive Coverage	__ Add/Remove Dependents
	Dependent	__ EE Only	__ EE + 1	__ EE + 2 or more	

ADDITIONAL LIFE	Action	__ No Change	__ Elect Coverage	__ Waive Coverage	
	Basic Life equal to your annual salary (county paid)	Total Amount $______________ *(increments of $10,000)* ** Supplemental life up to 5x your annual salary (Plan Max $300,000)*			__ Medical Underwriting Required *(see employee handbook for rules)*
SPOUSE LIFE	Action	__ No Change	__ Elect Coverage	__ Waive Coverage	
	Cannot exceed employee basic + additional life	Total Amount $______________ *(increments of $10,000)* ** Plan Max $250,000*			__ Medical Underwriting Required *(see employee handbook for rules)*
CHILD LIFE	Action	__ No Change	__ Elect Coverage	__ Waive Coverage	__ Add/Remove Dependents
	Children can only be covered by one employee	Total Amount	__ $5,000	__ $10,000	
STD	**Action**	__ No Change	__ Elect Coverage	__ Waive Coverage	__ Medical Underwriting Required *(see employee handbook for rules)*
	Amount	__ 15-Day Wait __ 30-Day Wait	__ 60-Day Wait __ 90-Day Wait	__ 120-Day Wait	

FSA	Action	__ No Change	__ Elect Coverage	__ Waive Coverage
	Deduction	Deduct $ __________ per pay period ($15 minimum)		
	Plan Option	__ Medical **available if HSA is not elected*		__ Limited Purpose **Dental/Vision expenses only*
DEP CARE	Action	__ No Change	__ Elect Coverage	__ Waive Coverage
	Deduction	Deduct $ __________ per pay period ($15 minimum)		
HSA	*Only available if electing the OrangePrime Plus plan (HDHP)*	__ HSA Election Form Attached (required for HSA Participation) __ N/A I do not qualify for or do not want an HSA		



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Dependent information: List all family members to be covered and only select coverage type desired.
** Include copies of all required dependent documentation as outlined in your current employee handbook*

Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
__ Spouse *Marriage Date:* __________				__ M __ F	__ Spouse Life	__ Elect __ Waive	__ Elect __ Waive	__ Elect __ Waive
__ Child __ Grandchild __ ________				__ M __ F	__ Disabled __ Court Order __ Child Life	__ Elect __ Waive	__ Elect __ Waive	__ Elect __ Waive
__ Child __ Grandchild __ ________				__ M __ F	__ Disabled __ Court Order __ Child Life	__ Elect __ Waive	__ Elect __ Waive	__ Elect __ Waive
__ Child __ Grandchild __ ________				__ M __ F	__ Disabled __ Court Order __ Child Life	__ Elect __ Waive	__ Elect __ Waive	__ Elect __ Waive

Notice of Enrollment Rights – *Please Read Carefully* – I understand that if I and/or my dependents, if any, waive coverage and desire to participate at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I Waive enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 60 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days after such event. Furthermore, employees are responsible for removing dependents from the plan within 60 days of the loss of eligibility event (i.e. divorce, dependent eligibility, etc). ***Any employee failing to provide the required information and documentation, or falsifying information and documentation, or listing ineligible individuals as eligible dependents, shall cause his or her dependents to be removed from the County's benefit plans. Additionally, that employee may be subject to disciplinary action up to and including termination of employment, may be required to reimburse the County for the benefits costs paid on behalf of the ineligible individual(s), and may be excluded from coverage all together under the County's benefits plans.***
The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my Wand/or my dependents' coverage and may subject me to disciplinary actions up to and including termination of employment. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I understand that coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. By signing this enrollment form, I hereby certify that all the information provided is true and correct.
Authorization to obtain or release medical information: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or confirmation pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original. I understand that some plans may contain a provision which excludes coverage for pre-existing conditions.
Authorization to provide identifying contact information: I authorize my employer to provide my identifying contact information (home address and telephone number) to any entity that manages, administers, evaluates or audits my employer's health care and benefits related programs, for the sole purpose of conducting those services, as applicable.
Payroll deduction authorization: I authorize my employer to reduce my salary in accordance with the benefits I have selected. I understand my selections cannot be changed unless I have a qualifying family status change as defined by the Federal Internal Revenue, Section 125 Code and request such changes within 60 calendar days of the qualifying event.

Please note, your requested plan change(s) will take 1-2 pay periods to be processed and become visible to you in applicable systems.

____ ________________ ____________________
Employee Signature EEID Date