# Gilchrist County BOCC Enrollment

☐ **New Hire** ☐ **Qualifying Event**

Department:_____ Effective Date: _____
*(The first day of the month following 30 days of employment)*

**Personal Information** *(Please complete the following information)*

| Employee Name (Last, First, MI) | Social Security # | Birth Date | Sex ☐ M ☐ F |
|---|---|---|---|
| | | | |

| Mailing Address | City | State | Zip | County |
|---|---|---|---|---|
| | | | | |

| Date of Hire | Home Phone | Annual Salary | Occupation |
|---|---|---|---|
| | | | |

Effective Date of Coverage | Work Status: ☐ Actively At Work ☐ Cobra ☐ Retired – Retired Date:

| **Family Status** | **Dependent Children** |
|---|---|
| ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced | ☐ Yes ☐ No |

**Coverage Elections**

| Plan | Coverage and Pay Period Deduction Amounts | | | | |
|---|---|---|---|---|---|
| | **Employee** | **Employee + Spouse** | **Employee + Children** | **Family** | **Decline Coverage** |
| **Florida Blue Base Plan #0727** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Florida Blue Buy-Up Plan # 03748** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Standard Dental** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Standard VSP Vision** | ☐ | ☐ | ☐ | ☐ | ☐ |

☐ I am refusing all Health Care Coverage at this time. I understand that if I decide to apply later, that coverage may not be available until the next open enrollment or special enrollment period. _____ Initial

If DECLINING MEDICAL COVERAGE, Are you covered under another plan? ☐ Yes ☐ No

Insurance Carrier: _____ Group Policy Number: _____

On the day coverage begins will you or any family member enrolling in this plan be covered by the following?

☐ Other Group/Individual coverage ☐ Medicare ☐ Medicaid

**Dependent Enrollment** *Provide the following information for any new enrollment or changes*

To qualify for DEPENDENT COVERAGE under any of the insurance benefits offered by Gilchrist County BOCC, the Dependent claimed must be a **legally dependent Spouse or Child** of a benefit eligible employee. If a Spouse is claimed, the Spouse must be legally married to the benefit eligible employee; if a Child is claimed, the benefit eligible employee must be legally responsible for the Child under the laws of the State of Florida.

| | Last Name, First, MI | Sex | Date of Birth | SSN | Full-Time Student |
|---|---|---|---|---|---|
| **SP** | | ☐ M ☐ F | | | **N/A** |
| **CH** | | ☐ M ☐ F | | | ☐ Yes ☐ No |
| **CH** | | ☐ M ☐ F | | | ☐ Yes ☐ No |
| **CH** | | ☐ M ☐ F | | | ☐ Yes ☐ No |

Are they dependent on you for support and maintenance? ☐ Yes ☐ No

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Print Employee Name: _____

I would like to elect to pre-tax the following payroll deduction(s):

| | | |
|---|---|---|
| Florida Blue Medical Coverage | ☐ Yes ☐ No | |
| Standard Dental Coverage | ☐ Yes ☐ No | |
| Standard Vision (VSP) Coverage | ☐ Yes ☐ No | |

I understand that:

- I **cannot change or revoke any of my elections** or this compensation redirection agreement at any time of the plan year unless I have a change in family status(including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I take an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, etc.).

**Notification of change must be within 30 days of the qualifying event**

- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.
- I hereby authorize my employer to reduce my cash compensation by the amount(s) indicated for each pay period during the plan year following the date on which this agreement is signed.
- If I do not file a new Agreement to Participate and a new Salary Reduction Agreement with the Plan Administrator before the start of each new Plan Year, it will assumed that I have selected the same benefits as in the previous Plan Year (excluding my Flexible Spending Account, which requires a plan selection each plan year) and my salary will be reduced accordingly by my Employer.
- I understand that if my required contribution to pay premiums for the elected benefits including all Medical, Dental, Vision, Accident, Cancer, Hospital, Health, Life, and Short Term Disability payroll deducted by Gilchrist County are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

*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.* ***Duty to review my pay records.*** *I understand I have a duty to review my pay records (pay stub, etc.) to confirm that my Employer has properly implemented my salary reduction election. Furthermore, I have a duty to inform the Benefits Department or Payroll Department if I discover any discrepancy between my pay records and this Premium Only IRS Code Section 125 Agreement. I understand that my failure to report any discrepancy may result in a loss of, or reduction in, my benefit elections. I understand should I leave the Company for any reason my coverage will extend until the end of the month and I am financially responsible for all related premium.*

**I have examined this agreement and to the best of my knowledge it is true, correct and complete. I have read and understand the IRS Code Section 125 provisions.**

I understand that should my employment with Gilchrist County terminate for any reason that my benefits will end the last day of the month following my last day worked. Health, Dental, and Vision will be available to me through COBRA. That information will be sent to you by COBRA. I understand that upon my termination other than retirement as defined in my Gilchrist County Policies and Procedures that my Life insurance benefits will end with Gilchrist County. It is my responsibility to apply for coverage through Standard Life Insurance.

- I acknowledge receipt of Standard Life Conversion/Portability
- I understand that I must be working a minimum of 30 hours a week to qualify for any benefits. Should my average working hours fall below 30 hours, I can be dropped from my elected plans.

_____ _____

**Enrollment Signature of Employee** **Date**

Standard Insurance Company **Enrollment and Change**

## To Be Completed By Human Resources

| Group Number | Division | Billing Category | Date of Employment |
|---|---|---|---|
| **751525** | | | |

## To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change ***Complete Beneficiary Section below.*** ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete _____

| Your Name (Last, First, Middle) | Your Social Security Number | Birth Date | ☐ Male ☐ Female |
|---|---|---|---|
| | | | |

| Your Address | City | State | ZIP |
|---|---|---|---|
| | | | |

| Former Name (Last, First, Middle) *Complete only if name change* | Phone Number |
|---|---|
| | |

| Employer Name | Job Title/Occupation |
|---|---|
| **Gilchrist County Board of County Commissioners** | |

| Hours Worked Per Week | Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year |
|---|---|
| | |

**Coverage** ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

**Life Insurance**

☒ Basic Life with AD&D (Employer Paid)

☐ Additional Life requested amount $_____

**Dependents Life Insurance**

☐ Spouse Life requested amount $_____

Spouse Name_____ Date of Birth_____

☐ Child(ren) Life requested amount $_____

**Beneficiary** ***This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

| Primary - Full Name | Address | Soc. Sec. No. | Relationship | % of Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |

| Contingent - Full Name | Address | Soc. Sec. No. | Relationship | % of Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Signature** I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

***Return completed form to your Human Resources Department.***

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

    1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

    2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

    3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____ ."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.