2020 Wellness For Life
New Hire Election Form

EMPLOYEE INFORMATION ☐ BCC ☐ CMP

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

ENROLLMENT TYPE: NEW HIRE/REHIRE **EVENT DATE:** _____ **EFFECTIVE DATE:** _____
(Rates listed below represent bi-weekly deductions)

MEDICAL

	☐ Add Coverage	☐ Waive Coverage		
OrangePrime Plus (HDHP)	☐ EE Only ($3.19)	☐ EE + SP ($104.44)	☐ EE + CH ($95.52)	☐ EE + Family ($213.35)
OrangePrime (LDHP)	☐ EE Only ($16.69)	☐ EE + SP ($126.18)	☐ EE + CH ($116.84)	☐ EE + Family ($243.69)
TRICARE Supplement	☐ EE Only ($31.15)	☐ EE + SP ($61.15)	☐ EE + CH ($61.15)	☐ EE + Family ($82.38)

HEALTH SAVINGS ACCOUNT
Only available if electing the OrangePrime Plus plan (HDHP)
☐ HSA Election Form Attached (required for HSA Participation)
☐ I do not qualify or do not want an HSA

DENTAL

	☐ Add Coverage	☐ Waive Coverage	
Low Plan	☐ EE Only ($5.80)	☐ EE + 1 ($11.81)	☐ EE + 2 or more ($21.60)
Middle Plan	☐ EE Only ($8.87)	☐ EE + 1 ($18.37)	☐ EE + 2 or more ($34.55)
High Plan	☐ EE Only ($14.45)	☐ EE + 1 ($29.42)	☐ EE + 2 or more ($53.46)

VISION

☐ Add Coverage	☐ Waive Coverage	
☐ EE Only ($2.88)	☐ EE + 1 ($5.75)	☐ EE + 2 or more ($8.44)

LIFE INSURANCE ☐ Add Coverage ☐ Waive Additional Life Coverage
**Must be in increments of $10,000*
Basic Life (County Paid): $ _____
Max Additional Allowed: $ _____
(Plan maximum of $300,000)
Add Additional Amount: * $ _____
☐ Medical Underwriting *(Required for elections greater than $200,000)*

SPOUSE LIFE INSURANCE ☐ Add Coverage ☐ Waive Coverage
**Must be in increments of $10,000*
Amount of Spouse Life cannot exceed Employee Basic + Additional Life
(Plan maximum of $250,000)
Add Spouse Life Amount: * $ _____
☐ Medical Underwriting *(Required for elections greater than $50,000)*

CHILD LIFE INSURANCE ☐ Add Coverage ☐ Waive Coverage
☐ $5,000 ($0.16)
☐ $10,000 ($0.31)
**If your spouse also works for the County, only one of you are eligible to cover your child/ren.*

SHORT TERM DISABILITY ☐ Add Coverage ☐ Waive Coverage
☐ 15-Day Wait _____ ☐ 60-Day Wait _____ ☐ 120-Day Wait _____
☐ 30-Day Wait _____ ☐ 90-Day Wait _____

FLEX SPENDING ACCOUNT ☐ Add Coverage ☐ Waive Coverage
☐ Medical FSA Deduct $ _____ per pay period ($15 minimum) ** Available if HSA is not elected*
☐ Limited Purpose FSA Deduct $ _____ per pay period ($15 minimum) ** Dental/vision expenses only*

DEPENDENT CARE FSA ☐ Add Coverage ☐ Waive Coverage
Deduct $ _____ per pay period ($15 minimum)

B001

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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 2020 employee handbook*								
Relationship	Last Name, First Name	DOB	SSN	Gender	Notes	Medical	Dental	Vision
☐ Spouse *Marriage Date:* __________				☐ M ☐ F	Spouse Life ☐ Add	☐ Add ☐ Waive	☐ Add ☐ Waive	☐ Add ☐ Waive
☐ Child ☐ Grandchild ☐ ________				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Add ☐ Waive	☐ Add ☐ Waive	☐ Add ☐ Waive
☐ Child ☐ Grandchild ☐ ________				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Add ☐ Waive	☐ Add ☐ Waive	☐ Add ☐ Waive
☐ Child ☐ Grandchild ☐ ________				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Add ☐ Waive	☐ Add ☐ Waive	☐ Add ☐ 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 decline 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

Attention HR: Do not accept or sign until all required documentation is received.

______________________________________ ______________ ________________
HR Representative Signature EEID Date

______________________________________ ______________ ________________
HR Reviewer Signature (HR Analyst or above) EEID Date