2019 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 ($3.06)	__ EE + SP ($100.43)	__ EE + CH ($91.85)	__ EE + Family ($205.14)
OrangePrime (LDHP)	__ EE Only ($15.75)	__ EE + SP ($119.04)	__ EE + CH ($110.22)	__ EE + Family ($229.89)
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)

DENTAL	__ Add Coverage	__ Waive Coverage	
Low Plan	__ EE Only ($5.45)	__ EE + 1 ($11.11)	__ EE + 2 or more ($20.33)
Middle Plan	__ EE Only ($9.50)	__ EE + 1 ($19.68)	__ EE + 2 or more ($37.01)
High Plan	__ EE Only ($15.47)	__ EE + 1 ($31.51)	__ EE + 2 or more ($57.26)

VISION	__ Add Coverage	__ Waive Coverage	
	__ EE Only ($2.99)	__ EE + 1 ($5.97)	__ EE + 2 or more ($8.77)

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: * $ ___________

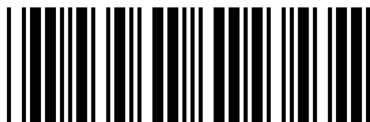
__Medical Underwriting *(Required for elections greater than $50,000)*

CHILD LIFE INSURANCE __ Add Coverage __ Waive Coverage
__ $5,000 ($0.16)
__ $10,000 ($0.32)
**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)



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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 2019 employee handbook*

Relationship	Last Name, First Name	DOB	SSN	Gender	Notes	Medical	Dental	Vision
__ Spouse *Marriage Date:* ____________				__ M __ F	Spouse Life __ Add	__ Add	__ Add	__ Add
__ Child __ Grandchild __ ________				__ M __ F	__ Disabled __ Court Order __ Child Life	__ Add	__ Add	__ Add
__ Child __ Grandchild __ ________				__ M __ F	__ Disabled __ Court Order __ Child Life	__ Add	__ Add	__ Add
__ Child __ Grandchild __ ________				__ M __ F	__ Disabled __ Court Order __ Child Life	__ Add	__ Add	__ Add

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 EEID Date