



Benefits Acknowledgements

Internal
Use Only

Please complete the following benefits acknowledgements by reviewing and initialing each of the lines below:

1) Notice of COBRA Continuation Coverage Rights

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under this law, the Orange County Board of County Commissioners (OCBCC) is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the plan would otherwise end due to certain qualifying events.

I acknowledge receiving my initial COBRA notification, which can be found in the Important information section of my benefits handbook, on the date indicated below. This notification outlines any potential rights and obligations under the Federal COBRA law to me and my covered family members (if any). I understand failure to make my spouse (if any) aware of this notification letter may result in a loss of potential COBRA rights for my dependents.

2) Benefits Election Acknowledgement

I understand that I have 30 calendar days from my date of hire to make my benefits elections. If I fail to submit my elections to the Benefits Department within 30 days of that date, I will be enrolled in core benefits. Core medical is the Orange Prime Local Sure Fit plan for the employee only. I understand that I will not be able to change this election until the next open enrollment period unless I have a qualifying event (i.e. marriage, divorce, birth, etc.). I understand that my benefit elections will become effective after all required enrollment documentation has been received and processed.

3) Benefits Coverage Effective Date Acknowledgement

I hereby acknowledge that I have been provided the link to the Orange County Employee Benefits webpage (<http://www.ocfl.net/EmploymentVolunteerism/NewHireBenefits.aspx>) that includes a copy of the Employee Benefits Handbook. By signing this document, I recognize that I am a regular full or part-time employee who is scheduled to work 20 hours or more per week, and I am currently eligible for the group insurance plans offered under the Wellness for Life Plan.

I acknowledge that I have received, read, and understand the enrollment and eligibility rules associated with Orange County Government, Wellness For Life Plan's Employee Benefits Handbook, which outlines the below listed benefits eligibility and effective dates for the current plan year.

4) I understand that I will be **enrolled in** the following coverage effective the date of hire: Basic Life Insurance and AD&D, Long Term Disability, Employee Assistance Program and Florida Retirement System (FRS).

5) I understand that I am **eligible for** the following additional coverage effective the date of hire, provided that all required paperwork is submitted by the Wednesday following my hire date. Medical, Dental, Vision, Short Term Disability, Supplemental Life and AD&D, Spouse Life, Child Life, Flexible Spending Accounts, and the Deferred Compensation 457(b) Plan. *Special rules apply for Health Savings Accounts (HSAs).

NOTE: Although I am eligible for coverage as of my hire date, coverage will not begin until my Election Form has been completed, submitted, and processed by the Administrator. Coverage will take effect at the start of the pay period in which the Election Form is approved. If the form is submitted and approved during a pay period, coverage will begin at the start of the following pay period. This shall not terminate any eligibility rights provided under applicable federal law (e.g., birth or adoption of child) or termination of participation rules under Section 3.04 of this plan document.

6) I understand that my healthcare benefits, through Orange County Government, will not be prorated, and that I am paying for my benefits on a per pay period basis, regardless of my benefits effective date.

7) Permanent Records

I understand this form will be part of my permanent records retained in my Personnel file. I further understand that I can request a copy of my employee records by contacting HR.Records@ocfl.net.

Print First and Last Name _____ Employee ID _____

Employee Signature _____ Date _____



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