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 Select One (QE Only) Prior app

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

B001 - Beneflex

Reset Form

51-109 10/2024

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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 SureFit PCP ID No. ______	☐ Elect ☐ Waive	☐ Elect ☐ Waive
☐ Child ☐ Grandchild ☐ ______				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive SureFit PCP ID No. ______	☐ Elect ☐ Waive	☐ Elect ☐ Waive
☐ Child ☐ Grandchild ☐ ______				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive SureFit PCP ID No. ______	☐ Elect ☐ Waive	☐ Elect ☐ Waive
☐ Child ☐ Grandchild ☐ ______				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive SureFit PCP ID No. ______	☐ 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 and/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