BENEFITS ENROLLMENT/CHANGE FORM

Please complete all applicable sections. Health, Dental and Prescription coverages are bundled.

TYPE OF ENROLLMENT
☐ Open Enrollment
☐ Add dependent*
☐ Cancel dependent*
☐New Hire/New Enrollment*

*QUALIFYING EVENT:
☐ Employment Status Change ☐ Divorce/Marriage
☐ Birth ☐ Loss of/Eligible for other coverage
Qualifying event date:_____Effective date of change is first of the month following the qualifying event.

1. Employee Data (please print)

NAME (FIRST, MI, LAST) | DATE OF HIRE | EMPLOYER NAME

STREET ADDRESS | CITY | STATE | ZIP

PHONE NUMBER | SOCIAL SECURITY NUMBER | GENDER | DATE OF BIRTH

2. Health Plan Coverage (Medical, Dental and Rx 2020-2021 Rates)

☐ Employee Only
$40/Pay Period – Employee
$365/Pay Period – Employer

☐ Employee + 1
$158/Pay Period – Employee
$634/Pay Period – Employer

☐ Employee + Family
$226/Pay Period – Employee
$906/Pay Period – Employer

Cigna. DELTA DENTAL MEDTRAKRx

3. Dependent Information

NAME (FIRST, LAST) | GENDER M/F | RELATIONSHIP TO EMPLOYEE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

NAME (FIRST, LAST) | GENDER M/F | RELATIONSHIP TO EMPLOYEE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

NAME (FIRST, LAST) | GENDER M/F | RELATIONSHIP TO EMPLOYEE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

NAME (FIRST, LAST) | GENDER M/F | RELATIONSHIP TO EMPLOYEE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

4. Other insurance information (if your coverage under your current plan will end when the County's plan begins, please mark NO

Do you or your dependents have additional healthcare coverage? ☐ YES ☐ NO
If yes, please provide name of carrier, member ID number and person(s) covered.

Name of Carrier | Member ID | Persons Covered

Employee Signature – The information provided above is true and correct to the best of my knowledge. Date / Employee #

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Payroll Use Only

Paycheck effective date

_____

I am declining coverage for myself and my dependents (if applicable).

Signature | Date | Employer Name