Lee County Human Resources

# Full-Time Employee Benefits Enrollment Checklist

Health & Wellness Benefits are effective 1st of the month following your date of eligibility

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**Step 1: Submit Paperwork (Within 2 Weeks of Hire Date)**

☐ Deliver to Human Resources in person
☐ OR scan/take photos and email securely to: benefits@leegov.com
☐ Questions? Call the benefits team 239-533-2245

⚠️ *Late paperwork may delay benefits and result in catch-up deductions*

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**Step 2: Complete ALL Required Forms**

***Forms must be signed and dated***
☐ Benefits Enrollment Change Form (elect or decline benefits)
☐ Beneficiary Designation Form
☐ Disclosure Form
☐ Employee COBRA Acknowledgement
☐ Spouse COBRA Acknowledgement (if enrolling a spouse)

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**Step 3: Optional Forms (If Enrolling)**

***Forms must be signed and dated***
☐ Additional Life Insurance Form
☐ Short-Term Disability Insurance Form
☐ Flexible Spending Account (FSA) Form
☐ Opt-Out Form

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**Step 4: If Enrolling a Spouse or Children in any insurance plan – Submit copies of Legal documents**

**Spouse:**
☐ Birth certificate or driver's license or US Passport
☐ Social Security card
☐ Marriage certificate

**Dependents – Children**:
☐ Birth certificate
☐ Social security card
☐ Legal documentation for adoption, fostering, or court appointed guardianship
☐ Stepchildren: Marriage certificate, birth certificate and social security card

**Don't forget! Your paperwork is due within 2 weeks of your hire date**

Lee County Human Resources

**MEMORANDUM FROM THE DEPARTMENT**

**OF HUMAN RESOURCES**

TO: New Employees

FROM: Lee County
Employee Benefits Department
239-533-2245

Re: Benefit Elections

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There are several changes that employers have made as a result of Healthcare Reform. Under the Affordable Care Act (also known as the ACA and Federal Healthcare Reform), Lee County, as your benefits administrator, is required by the U.S. Department of Labor to provide you with the attached notice.

The purpose of the notice is to provide employees with information concerning the Health Insurance-Marketplace, also known as "Exchanges". The Exchanges are a competitive insurance marketplace, established by the government, where individuals and small firms can shop among health plans for coverage. Lee County provides **affordable coverage** (the employee's required contribution for employee-only coverage exceeds 9.5% of household income), **minimum essential coverage** (the minimum insurance package that fulfills the requirements of the mandate that all individuals carry insurance) and **minimum value** (the employer must provide coverage at the 60% level) to all employees. All employees are eligible to purchase insurance in the Health Insurance Marketplace, but not all employees will be eligible for the subsidy.

You can obtain the contact information for Florida's health insurance marketplace, which became available October 1, 2013, from HealthCare.gov or go online at: https://www.leegov.com/hr/employees/hipaa

If you have general questions about healthcare reform or state health exchanges, you may contact Human Resources Benefits at 239-533-2245.

Best regards,

Lynne Peterson
Manager, Department of Human Resources
Lee County Board of County Commissioners

**MEMORANDUM FROM THE**
**DEPARTMENT OF HUMAN RESOURCES**

**TO:** New Employees

**FROM:** Lee County
Employee Benefits Department
239-533-2245

**RE: FINAL CHOICE – LEE COUNTY BENEFITS PLAN**

The decisions on the benefits options you choose must be received in the Human Resources Benefits Office not later than two weeks after your original New Employee Orientation.

In order to serve all participants to the best of our ability, the Benefits Office Staff cannot guarantee the timely processing of your information and the issuance of your insurance identification cards if your enrollment forms are not returned by the requested deadline.

This is your only opportunity to take advantage of enrolling in Medical, Dental, Vision, FSA Reimbursement Accounts; covering dependents on your insurance plans; or to elect Short Term Disability and/or Optional Life Insurance coverage at a Guaranteed Issue. The enrollment forms are provided to you in your benefit information package. If you do not have the forms, please contact our office or stop by immediately so that they can be provided to you.

Documentation is required if you wish to cover a spouse and/or child(ren) on any insurance plan prior to your dependents being enrolled in any insurance plan. These are used to verify information and proof of relationship. The required documents are:

- **Spouse Enrollment:** Copies of 1) Marriage License, 2) Social Security Card, and 3) Passport, Birth Certificate, or Driver's License.

- **Dependent Children:** Copies of Birth Certificate and Social Security Card.

  In some instances, you may be asked to provide court orders, custody documents, or legal guardianship paperwork.

Review your paystubs during the month in which your benefits become effective for accuracy of insurance plan payroll deductions.

***If you do not submit enrollment paperwork prior to your effective date, you will be enrolled in Life Insurance and Long Term Disability only. These are employer-paid benefits. All other plans involve payroll deductions and require your authorization.***

Your next opportunity to make changes to your plans will be Open Enrollment which occurs in November each year. Some changes may require Evidence of Insurability (EOI).

If you have any questions, please do not hesitate to call Human Resources Benefit Team 239-533-2245

Lee County Human Resources

# 2026 BENEFIT PREMIUMS

| | COVERAGE LEVEL | EMPLOYEE PER MONTH | EMPLOYER PER MONTH |
|---|---|---|---|
| **Medical: Aetna Select and Aetna POSII** | Employee Only | 15.00 | 1,565.00 |
| | Employee & Dependents | 115.00 | 2,230.00 |
| | Employee & Spouse | 145.00 | 2,230.00 |
| | Employee & Family | 160.00 | 2,230.00 |
| | Overage Dependent + employee cost age 26 – 30 | 1,580.00 | -0- |
| **Dental** | Employee Only | 5.00 | 37.00 |
| | Employee & Family | 40.00 | 37.00 |
| **Vision** | Employee Only | 8.45 | -0- |
| | Employee & Family | 16.45 | -0- |
| | Employee Only – High | 14.70 | -0- |
| | Employee & Family – High | 28.07 | -0- |
| **Basic Life** | One Times Annual Salary | FREE | 0.179 / $ 1,000 coverage |
| **Long-term Disability** | 60% of pre-disability salary | FREE | 0.256 / $100 of monthly salary |

**Premiums are deducted as follows for BOCC Employees:** Medical- half from the first check and half from the second check of the month; Dental- first check of the month; Optional Life, Vision, and Short-Term Disability- second check of the month.

| **Short – Term Disability Insurance Cost = Age Rate x Gross weekly salary (GWS)** | | |
|---|---|---|
| **Employee Age Range** | **Premium Rate** | **X Gross Weekly Salary** |
| 29 and under | 0.667 | X $10.00 of GWS |
| 30 - 39 | 0.340 | X $10.00 of GWS |
| 40 - 49 | 0.369 | X $10.00 of GWS |
| 50 - 59 | 0.469 | X $10.00 of GWS |
| 60 - 64 | 0.667 | X $10.00 of GWS |
| 65 + | 1.121 | X $10.00 of GWS |
| Premium Adjustments: Your monthly premium rate will be re-calculated anytime your age and/or salary change. | | |

**Optional Life Insurance (Per $1,000 of Plan Value) – Employee Paid**

| Age Range | Premium Rate |
|---|---|
| 29 and under | $ .06 / $1,000 |
| 30 – 34 | $ .08 / $1,000 |
| 35 – 39 | $ .09 / $1,000 |
| 40 – 44 | $ .10 / $1,000 |
| 45 – 49 | $ .16 / $1,000 |
| 50 – 54 | $ .24 / $1,000 |
| 55 – 59 | $ .45 / $1,000 |
| 60 – 64 | $ .67 / $1,000 |
| 65 – 69 | $ 1.31 / $1,000 |
| 70+ | $ 2.14 / $1,000 |
| All Eligible Children | $ .65 / $5,000 |

*Amounts of coverage for an active employee reduce to 67% of face amount at age 65; 50% at age 70; and 35% at age 75. Your rate increases on January 1st of the year following your birth date.

# Medical Plans

| Service | Select In-Network Only | POS II In-Network | POS II Out-Network |
|---|---|---|---|
| Deductible | N/A | N/A | $500/$1,000 |
| Coinsurance | N/A | N/A | 70% / 30% |
| Primary Care | $10.00 | $10.00 | 70% / 30% |
| Specialist | $45.00 | $55.00 | 70% / 30% |
| Tela Doc | $10.00 | $10.00 | N/A |
| Urgent Care | $50.00 | $50.00 | 70% / 30% |
| Behavioral Health | $10.00 | $10.00 | 70% / 30% |
| Diagnostic Testing Lab Corp or Quest | $25.00 | $35.00 | 70% / 30% |
| Complex Imaging (Pre-Authorization Required) | $50.00 | $50.00 | 70% / 30% |
| Emergency Room | $225.00 | $225.00 | N/A |
| Outpatient Surgery | $200.00 | $200.00 | 70% / 30% |
| In-Patient Hospital | $500.00 | $500.00 | 70% / 30% |

# BENEFITS ENROLLMENT AND CHANGE FORM

Lee County Human Resources

☐ New Hire ☐ PT to FT Effective Date: _____

☐ Change Reason: _____

## EMPLOYEE INFORMATION

| | | | | |
|---|---|---|---|---|
| **First Name** | **MI** | **Last Name** | **SSN** | **Date of Hire** |
| **Street Address** | | | **City/State/Zip** | **Date of Birth** |
| **Entity** | *Salary* | **Department** | **Email** | **Home Phone** |

## MEDICAL, DENTAL, VISION ELECTIONS

| | Aetna Select | Aetna POS II | Dental | Vision Basic | Vision High |
|---|---|---|---|---|---|
| **Employee Only** | ☐ $15.00 | ☐ $15.00 | ☐ $5.00 | ☐ $8.45 | ☐ $14.70 |
| **Employee & Family** | ☐ $160.00 | ☐ $160.00 | ☐ $40.00 | ☐ $16.45 | ☐ $28.07 |
| **Employee & Spouse** | ☐ $145.00 | ☐ $145.00 | | | |
| **Employee & Children** | ☐ $115.00 | ☐ $115.00 | | | |
| **Decline** | ☐ | ☐ | ☐ | ☐ | ☐ |

## FAMILY INFORMATION

**Below place an "A" to Add, "R" to Remove**

| **Name: First, MI, Last** | **SSN** | **Date of Birth** | **Relationship** (**S**)pouse (**D**)ependent (**G**)randchild | **Sex** **M** **F** | **Medical** **A** **R** | **Dental** **A** **R** | **Vision Basic** **A** **R** | **Vision High** **A** **R** |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**SIGNATURE:** _____ **PRINTED NAME:** _____ **DATE:** _____

**PRETAX PREMIUM PLAN:** Medical, dental, vision, and flexible spending account contributions will not be subject to Federal Income or Social Security taxes and changes to your coverage can only be made as a result of an approved qualifying change in family status.

**NOTE: IMPORTANT INFORMATION PLEASE READ AND REVIEW. YOU ARE AUTHORIZING A RELEASE OF YOUR MEDICAL INFORMATION**.

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION:** I authorize any health care professional or entity to give the health plan/insurer or any of their designees, all records or information 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.

**IMPORTANT INFORMATION:** By signing this form, I affirm that all information provided is accurate and complete. I understand that any omissions, incorrect statements, or falsified documentation—whether intentional or unintentional—may result in the denial or termination of coverage for myself and/or my listed dependents. I hereby affirm and attest that the dependent(s) listed meets the requirements of eligibility. If any dependent is determined to be ineligible or I fail to notify Human Resources of a loss of eligibility or any supporting documentation is not provided upon request or documentation is falsified intentionally or unintentionally, I understand that I may be liable for all claims paid for any dependent deemed ineligible and I may be subject to disciplinary action up to and including termination of employment. I understand that knowingly submitting false, incomplete, or misleading information in a claim or application with intent to defraud or deceive any insurer is considered a criminal offense. Coverage will only become effective on the date specified by the insurer, following approval of this application and payment of the first full premium.

**Overage Dependent Verification:** If any dependent (not including your spouse), listed above is 26 or older, the appropriate Overage Dependent Affidavit (26-30) must be completed and returned to Human Resources for coverage to become effective.

**Authorization for Payroll Deduction**: I herby authorize my employer to adjust my salary in accordance with the above elections. I have read and fully understand the rules above that govern my benefit elections. I understand that falsification of any information on this application or my reimbursement claim forms may result in termination of my employment.

# LEE COUNTY HEALTH PLAN "OPT-OUT" ENROLLMENT FORM-$50 per Month

**Lee County Board of County Commissioners**

Name (Last, First, MI): _____ SS#: xxx-xx-_____

*(Please print)* *(Required)*

**Effective Date of Enrollment:** _____ Dept: _____

**BoCC employees may not participate in the Opt-Out plan, if they are covered by another Lee County or covered entity plan.**

By signing this agreement, I understand all aspects of this plan as they have been presented to me, and agree to all the terms of this benefit.

- Enrollment in this plan takes effect for all new employees when all other benefits become active. Existing employees can *ONLY* enroll during open enrollment that becomes effective on January 1 of the next plan year. ***You must present proof of your other insurance to qualify.***

- While enrolled in this plan, I will not be eligible to rejoin the Lee County Health Plan until the next annual open enrollment period benefits become effective on January 1st of the following plan year. ***Unless*** I experience a qualifying event, that allows re-enrollment, as defined in the Lee County's Health Plan documents.

- I am responsible for reporting to Human Resources any change in my health insurance *status within 60 days of the date of any qualifying event* which would allow me to rejoin the Lee County Health Plan. This is done by submitting an enrollment and change form with the appropriate documents attached (i.e., proof of loss of health insurance coverage, etc.). If I do not contact Human Resources to report an event within the specified time limit, I will NOT be eligible to rejoin the health plan until the next open enrollment period.

- Should I experience a qualifying event during the plan year and rejoin the Lee County Health Plan, I will not be eligible for re-enrollment in the Opt-Out benefit, regardless of my health insurance status, until the next open enrollment period.

- In order to re-enroll once I have cancelled the "Opt-Out Plan", I must present proof of other insurance coverage to re-qualify for the plan during open enrollment as well as provide a new written waiver of coverage.

**Note:** Once enrolled, participation will automatically "roll over" into each succeeding plan year unless the employee has rejoined the health plan. ***Rejoining the health plan at any time will automatically STOP the opt-out benefit payment of $50 per month.***

Employee Signature: _____ Date: _____

**Standard Insurance Company**

Lee County Board of County Commissioners
**Beneficiary Designation Form**

I Am Completing This Form for: ☐ Basic Life/ADD ☐ Additional ☐ Both

| **Employee Name *(First, Middle, Last)*** | ***Date of Birth*** | **Social Security Number** |
|---|---|---|
| | | |
| **Address *(Street, City, State, Zip Code)*** | | **Phone Number** |
| | | |

- This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance and Life with Accidental Death & Dismemberment (AD&D) Insurance.
- Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime.
- Return the completed form to your Human Resources Department.

**Primary Beneficiary (the total of all primary beneficiaries must equal 100%)**

| | Name (First, Middle, Last) | Date of Birth | Social Security Number | Relationship | % of Benefit |
|---|---|---|---|---|---|
| **1.** | | | | | |
| | Address | | | Phone Number | |
| | | | | | |
| **2.** | Name (First, Middle, Last) | Date of Birth | Social Security Number | Relationship | % of Benefit |
| | | | | | |
| | Address | | | Phone Number | |
| | | | | | |
| **3.** | Name (First, Middle, Last) | Date of Birth | Social Security Number | Relationship | % of Benefit |
| | | | | | |
| | Address | | | Phone Number | |
| | | | | | |

*The total share of all primary beneficiaries must equal 100%* **TOTAL**

**Contingent Beneficiary (the total of all contingent beneficiaries must equal 100%)**

| | Name (First, Middle, last) | Date of Birth | Social Security Number | Relationship | % of Benefit |
|---|---|---|---|---|---|
| **1.** | | | | | |
| | Address | | | Phone Number | |
| | | | | | |
| **2.** | Name (First, Middle, Last) | Date of Birth | Social Security Number | Relationship | % of Benefit |
| | | | | | |
| | Address | | | Phone Number | |
| | | | | | |
| **3.** | Name (First, Middle, Last) | Date of Birth | Social Security Number | Relationship | % of Benefit |
| | | | | | |
| | Address | | | Phone Number | |
| | | | | | |

*The total share of all contingent beneficiaries must equal 100%* **TOTAL**

| **Employee Signature:** | **Date:** |
|---|---|
| | |

*Complete form and retain a copy for your records.*

# Standard Insurance Company

## Remember the following when completing your Beneficiary Designation form:

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian, or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example," Dorothy Q. Smith, Trustee under the trust agreement dated_____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefits" box (es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe. 60%, Jane Q. Doe, 40%.

## To assist you, here are some examples of clear beneficiary designations.

| One Primary and two Contingent Beneficiaries | One Primary and three Contingent Beneficiaries |
|---|---|
| **Primary Beneficiary:**<br>Jane Smith, Spouse, 100%,<br><br>**Contingent Beneficiaries:**<br>Paul Jones, Brother, 50% Mary Park, Sister, 50% | **Primary Beneficiary:**<br>Gayle Rich, Spouse, 100%<br><br>**Contingent Beneficiaries:** Teresa Rich, Daughter, 40% Susan Rich, Daughter, 40% Jason Rich, Brother, 20% |

*Complete form and retain a copy for your records. Please return the completed form to Lee County Human Resources at benefits@leegov.com or via mail.*

Lee County
Southwest Florida

Human Resources

The Standard Insurance Company

Lee County Board of County Commissioners - Group #164657

## OPTIONAL LIFE INSURANCE

☐ New Hire Enrollment

☐ Change in Enrollment - *after initial enrollment call HR for detailed information*

Hire Date: _____

Effective Date: _____

Department/Entity: _____

## To be Completed by the Employee

Employee Name:

Last: _____ First: _____ MI __

Social Security Number: _____

Date of Birth: _____

Male ☐ Female ☐

Street Address: _____

City: _____ State: ___ Zip: _____

Phone Number: _____

## Do you wish to Enroll in Additional / Optional Life Insurance *(check all that apply)* - ***NOTE:*** *Evidence of Insurability (health questions) may be required. Contact your Human Resources Department about coverage options.*

☐ EMPLOYEE: **Additional** Amount Requesting $_____

New Hires - *You may elect a minimum of $25,000 in increments of $1,000 up to a **guarantee issue amount of $300,000** without submitting health questions. You may elect $301,000 up to a maximum of $500,000 - requires *****Evidence of Insurability/Health Questions and a decision by the carrier.*

☐ SPOUSE: **Additional** Amount Requesting $_____ Spouse Name _____ DOB_____

*You may elect a minimum of $25,000 in increments of $1,000 up to a **guarantee issue amount of $50,000** without submitting health questions. You may elect $51,000 up to a maximum of $250,000 - requires *****Evidence of insurability/Health Questions and a decision by the carrier.*

**NOTE:** *You may not enroll your spouse for more than half (50%) of your additional amount.*

☐ CHILD (REN): **Additional** Amount Requesting $_____ **NOTE:** when electing this coverage, it applies to all children who are eligible. You may elect a minimum of $5,000 in increments of $5,000 up to a maximum of $25,000 (health questions are not required). You may not enroll your child (ren) for more than half (50%) of your additional amount.

**Employee Signature Required:** **Date:**

**Signature:** *I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.*

Return completed form to your Human Resources Department
or send to our secure email - benefits@leegov.com

***Evidence of Insurability (Health Questions)** may be completed online at: https://myeoi.standard.com/164657*
*You will receive a decision directly from the carrier. Do **NOT** send health information to HR.*

Standard Insurance Company

# Short Term Disability Enrollment and Change

## To Be Completed By Human Resources

| Group Number | Division | Billing Category | Date of Employment |
|---|---|---|---|
| **164657** | | | |

## To Be Completed By Applicant ☐ Apply for Coverage

| Your Name (Last, First, Middle) | Your Social Security Number | Birth Date | ☐ Male ☐ Female |
|---|---|---|---|
| Your Address | | City | State / ZIP |
| Former Name (Last, First, Middle) *Complete only if name change* | | Phone Number | |
| Employer Name **Lee County Board of County Commissioners** | | Job Title/Occupation | |
| Hours Worked Per Week | Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year | | |

**Coverage** ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

**Voluntary Short Term Disability**

| **Your age** (as of last January) | **Rate** per $10 of STD benefit |
|---|---|
| <30 | $0.667 |
| 30-39 | $0.340 |
| 40-49 | $0.369 |
| 50-59 | $0.469 |
| 60-64 | $0.667 |
| 65+ | $1.121 |

To calculate your monthly payroll deduction, use the formula indicated below:

1. Enter your average weekly earnings, not to exceed $1000.00 on Line 1. Line 1: _____
2. Multiply your weekly earnings (Line 1) by .60 and enter on Line 2. Line 2: _____
3. Select your rate from the rate table and enter on Line 3. Line 3: _____
4. Multiply Line 2 by the amount Entered on Line 3. Line 4: _____
5. Divide the amount entered on Line 4 by 10 and enter on Line 5. Line 5: _____

The amount shown on Line 5 is your estimated monthly payroll deduction.

**Signature** I wish to enroll in Short Term Disability. I authorize deductions from my wages to cover my contribution toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required_____ Date (Mo/Day/Yr) _____

**Return completed form to your Human Resources Department or send to our secure email - benefits@leegov.com**

***Evidence of Insurability (Health Questions)** may be completed online at: *https://myeoi.standard.com/164657*
You will receive a decision directly from the carrier. Do NOT send health information to HR.

Lee County Human Resources

# FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

*To enroll, complete the following information, sign the form, and return it to **Human Resources**. To avoid processing delays, please complete all fields on the application and print clearly.*

**Department:** _____

**Employee Name:** _____ **SSN:** XXX-XX-_____

**Employee Address/City/State/Zip code:** _____ **Phone Number:** _____

## EMPLOYEE'S FLEXIBLE SPENDING ACCOUNT ELECTION

**Enrollment Reason** (please check one): ☐ **New Hire** ☐ **Open Enrollment** ☐ **Other:** _____

**FSA Election Effective Date:** _____ **Payroll Frequency : *Bi-Weekly**

***Annual Elected FSA Amounts are deducted from two pay periods each month, which will consist of 24 deductions per year.**

☐ I hereby elect NOT to participate in the Flexible Spending Accounts
☐ I hereby elect to participate in the following Flexible Spending Accounts:

| Benefit | Per Pay Period<br>*$25 minimum* | # Pay Periods<br>*24 annually, or number of pay periods remaining in the calendar year* | Annual Election Amount |
|---|---|---|---|
| ☐ **Healthcare FSA** *(medical, dental, vision expenses not covered by any plan)*<br>*$3,400* **annual maximum** | **$** | | **$** |
| ☐ **Dependent Care FSA** (*out-of-pocket **day care expenses** children under age 13 or elder tax dependent for whom you are responsible)*<br>**$*7,500* annual maximum** | **$** | | **$** |

I understand the choices I have indicated above are IRREVOCABLE unless a "qualifying status change" occurs as defined by the Internal Revenue Service. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Service Code Section 125 if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for expenses are not filed within the required time-period. I understand if I am terminated, discharged, or have my hours reduced to less than 30 hours per week, I will be automatically terminated from the plan. If termination from the plan occurs either voluntarily or involuntarily, or if I stop all contributions, no *benefits will be paid for any expenses incurred for dependent care and/or medical services after the termination date, and any plan contributions made after the termination date will be refunded, subject to taxation.*

***I hereby authorize Lee County to adjust my salary in accordance with the above elections. I have read and fully understand the rules governing this plan. If for any reason the information provided above should change, I will immediately notify my employer. I understand that falsification of any information on this application or my reimbursement forms may result in termination of my employment and will require full reimbursement by me of all benefits paid under this plan.***

**Employee Signature** **Date**

1825 Hendry Street - Suite 200
Fort Myers, FL 33901
Phone (239)533-2245. Fax (239)533-2052. benefits@leegov.com

Lee County Human Resources

# LEE COUNTY BENEFITS DISCLOSURE FORM

Name:_____ DATE: _____

Department:_____

The purpose of this form is for new enrollees in the Lee County Benefit Plans to disclose their current participation in any of the plans as a spouse or dependent of another employee.

The Lee County Benefit Plans do not allow dual coverage for participants. Employees may not be enrolled in any of the insurance plans as both an employee **and** a dependent.

Additional Life Insurance does not permit an employee to be covered as a dependent under our plan if the employee's spouse or parent is a member of our plan. Employees must request and enroll in the Additional Life Insurance as a member not a dependent.

Please answer the following questions:

1) Do you have a spouse, parent or dependent who works for Lee County BOCC or one of the other participating entities listed below? ☐ Yes ☐ No

2) If you answered yes to question #1, please place a checkmark next to the entity below:

| | | |
|---|---|---|
| ☐ BOCC | ☐ Elections | ☐ Port Authority |
| ☐ Captiva Fire Dept. | ☐ Fort Myers Beach Fire Dept. | ☐ Property Appraiser |
| ☐ Clerk of Courts | ☐ Fort Myers Shores Fire Dept. | ☐ Sanibel Fire Dept. |
| ☐ Court Administration | ☐ Medical Examiner | ☐ Upper Captiva Fire Dept. |
| ☐ LAMSID | ☐ Mosquito Control | ☐ |

3) Are you currently covered under any of the Lee County Insurance Plans as a spouse or dependent? ☐ Yes ☐ No

If you answered yes, please provide the following information:

Provide the name of the employee who has the coverage: _____

Check the Plans in which you have coverage:

| | |
|---|---|
| ☐ Medical | ☐ Vision |
| ☐ Dental | ☐ Additional Life |

Employee Signature: _____

# COBRA Acknowledgement Form
# New Enrollment

**Name:** _____ **Date:** _____

**Governmental Entity:** (check one)

☐ BOCC ☐ Lee County Clerk of Courts ☐ Court Administration

☐ Port Authority ☐ Property Appraiser ☐ Elections

☐ Other _____

I have received a copy of my rights regarding limited continuation of coverage for health benefits for myself and my covered dependents under Public Law 99-272, Title X.

_____ _____

Signature Date

**Please return this completed form to our secure email - benefits@leegov.com, or fax/mail:**

**Lee County Human Resources**
**Attn: Benefits**
**P.O. Box 398**
**Fort Myers, FL 33902**

**Phone: 239.533.2245**
**Fax: 239.485.2052**

Lee County Human Resources

**Required Documentation**
**Important Benefit Information**

***Legal documentation is required if you wish to cover a spouse and/or children on any insurance plan.***

**Legal Spouse:**

- Birth certificate or driver's license or US passport
- Social security card
- Marriage certificate

**Dependents - Children**

- Birth certificate
- Social security card
- Legal Documentation for adoption, fostering, or court appointed guardianship
- Step-children- marriage certificate, birth certificate & social security card

If you have any questions prior to your first day of employment regarding your benefits, please feel free to contact the Benefits Team at 239-533-2245.

Lee County Human Resources

# COBRA Acknowledgement Form for Spouse

Your spouse was given a copy of an initial COBRA notice upon commencement of employment, with instructions to deliver a copy to you. This certifies that you have received a copy of your rights pertaining to limited continuation of coverage for health benefits for you and your covered dependents under the Public Health Services Act.

_____ _____

(Print EMPLOYEE'S name) (EMPLOYEE'S SSN)

_____

(Print SPOUSE'S name)

**Governmental Entity: (check one or indicate other)**

☐ BOCC ☐ Lee County Clerk of Courts ☐ Court Administration

☐ Port Authority ☐ Property Appraiser ☐ Elections

☐ Other _____

_____ _____

Spouse's Signature Date

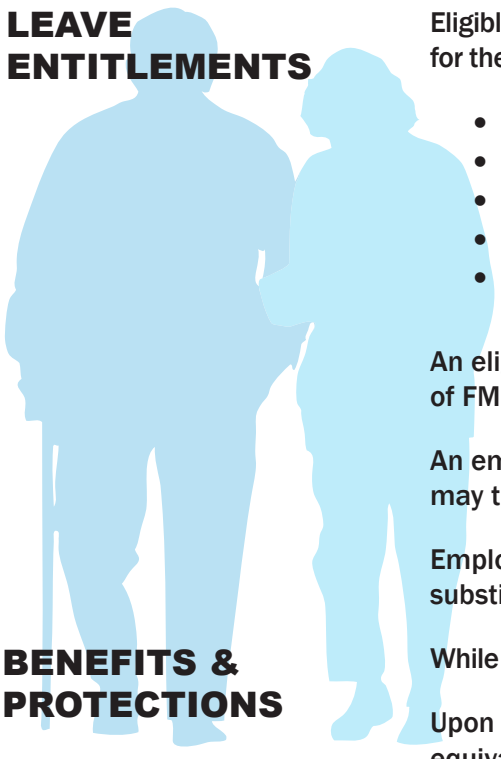
**Please return this completed form to our secure email - benefits@leegov.com, or fax/mail:**

Lee County Human Resources
Attn: Benefits
P.O. Box 398
Fort Myers, Florida 33902

**Phone: 239.533.2245**
**Fax: 239.485.2052**

# EMPLOYEE RIGHTS
## UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



### LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

### BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

### ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

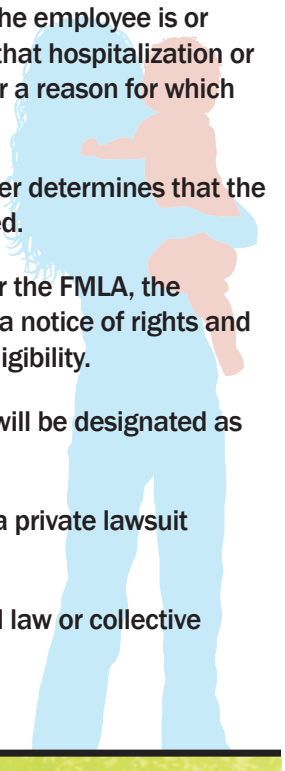
*Special "hours of service" requirements apply to airline flight crew employees.

### REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



### EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

### ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

**1-866-4-USWAGE**

(1-866-487-9243) TTY: 1-877-889-5627

**www.dol.gov/whd**

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

WH1420 REV 04/16

# VERY IMPORTANT NOTICE

Group Health Continuation under COBRA
**(Consolidated Omnibus Budget Reconciliation Act)**
For the LEE COUNTY BENEFITS PLAN

If you, your spouse, or your dependent children lose coverage under our health, dental, vision and flex spending plans because of a *qualifying event*, then you may have the right to elect continuation coverage under the Public Health Services Act, also known as **COBRA** coverage.

***Who May Elect Continuation Coverage?***

An employee, spouse or dependent child who has coverage under our group health and dental plan on the day before a qualifying event may elect continuation coverage. An employee may also elect continuation coverage for children born or adopted by the employee during the continuation period.

For families that lose coverage, each family member can separately elect continuation coverage. However, unless otherwise specified, an employee's election to continue coverage will be deemed to include an election of continuation for the employee's spouse and dependent children. Similarly, a spouse's election to continue coverage will be deemed to include an election of continuation for any dependent child covered by the plan.

Although an employee and spouse can continue coverage on behalf of other family members, they cannot decline coverage on behalf of other family members. For example, if an employee declines continuation coverage, the spouse or dependent child can elect to continue their coverage.

***What Is Continuation Coverage?***

If you or your child experiences a qualifying event, you may continue the health coverage you had immediately before the event occurred. If you continue coverage, you will not have to provide proof of insurability in order to continue coverage, and during open enrollment periods, you will have the same rights as active employees to change your coverage.

***What Is a Qualifying Event?***

A *qualifying event* occurs when you or a dependent child loses coverage under Lee County's health and dental plan because:

- A covered employee terminates employment for any reason other than gross misconduct or has a reduction in hours to fewer than the number required for plan participation.
- A covered employee dies.
- A covered employee becomes divorced from the spouse.
- A covered employee, or retiree becomes covered by Medicare.
- A covered child loses dependent status under a plan.

***Do I Have to Notify Lee County of Any Qualifying Events?***

Employees or their families must notify Lee County in the event of a divorce, or when a child no longer qualifies as a covered dependent under the plan within 60 days after these events occur. *Individuals failing to notify Lee County of these events within the 60-day period will not be permitted to continue coverage.*

***Can I Have More Than One Qualifying Event?***

Sometimes, a spouse or dependent child can have more than one qualifying event. A second qualifying event occurs if the following three conditions are met:

- The first event is the employee's employment termination or reduction in hours.
- The second event is a sort that gives rise to 36 months of continuation coverage (e.g., a covered employee's death or divorce).
- The second event takes place while continuation coverage is in effect.

If a second qualifying event occurs, we will extend the maximum coverage period from 18 months to 36 months, measured from the date of the first qualifying event. A qualified beneficiary is not entitled to more than 36 months of continuation coverage.

***How Do I Elect Continuation Coverage?***

If you and/or dependent children have a qualifying event, we will send you a notice of your continuation rights. At that time, you will have up to 60 days to decide whether you want to continue your health coverage through the Lee County plan. This election period will end 60 days from the later of the following two dates:

- The date coverage would otherwise terminate.
- The date the company notifies you of your continuation rights.

***How Long Can I Continue Coverage?***

If the qualifying event is employment termination or reduction in hours, the maximum period of time you can continue coverage is 18 months from the date of the qualifying event. For other qualifying events, the maximum period is 36 months. However, if the employee is covered by Medicare prior to the time of the termination or reduction, the period of coverage for the spouse and dependents will end after 18 months or, if greater, 36 months from the date the employee became covered by Medicare.

***Can Lee County Terminate My Continuation Coverage Before the Maximum Coverage Period Ends?***

Lee County can terminate your continuation coverage before the maximum coverage period ends for any of the following reasons:

- Payment for continuation coverage is not received on a timely basis.
- After electing continuation coverage, you become covered by another group health plan maintained by another employer that does not limit or exclude your coverage for any preexisting medical condition.
- After electing continuation coverage, you become covered by Medicare.
- Lee County ceases to provide group health plan coverage for all active employees.
- For cause, such as submission of a fraudulent claim.

***Do I Have to Pay for My Continuation Coverage?***

You must pay the full cost of continuation coverage, plus 2 percent for Lee County's administrative expenses. We will include information on the cost of continuation coverage and the payment terms in notices to individuals who have a qualifying event.

***Do Special Provisions Apply to the Disabled?***

If the Social Security Administration determines that you were disabled at any time during the first 60 days of continuation coverage, you can request an extension in the maximum coverage period from 18 to 29 months. This extension applies not only to the disabled individual, but also to covered family members.

To obtain this extended coverage, you must notify the plan administrator at the address below within 60 days of Social Security's disability determination and 18 months of the qualifying event.

If you receive this extended coverage, you must pay 102 percent of the full cost of the continuation coverage for the first 18 months. After 18 months, the required payments will increase from 102 percent to 150 percent of the full cost of coverage if the disabled individual elects the extended coverage. Otherwise, the required payments will remain at 102%.

If you receive the extended coverage, you are required by law to notify the plan administrator that you are no longer disabled within 30 days of any such determination made by Social Security. Once notified, your extended coverage will be terminated effective the first month beginning more than 30 days after Social Security's determination.

***Who Can I Contact If I Have Questions About Continuation Coverage?***

If you have any questions about continuation coverage, please contact Lee County Human Resources - Benefits at 239-533-2245.

This General Notice does not fully describe COBRA or the Lee County Benefits Plan. More complete information is available by reviewing the Summary Plan Documents located on our web site at **www.lee-county.com**. Click on County Departments; scroll down to Human Resources; click on Employee Benefits; scroll to the bottom of the page and select Summary Plan Documents; choose the plan you wish to view.

HIPAA (Health Insurance Portability and Accountability Act)

This legislation was passed to allow employees certain rights with respect to health plan waiting periods, special enrollments and pre-existing conditions. HIPAA requires employers providing group health coverage to employees to provide a Certificate of Creditable Coverage (also known as a HIPAA Certificate) to any participant who, for any reason, is no longer participating in the plan. If your last day of coverage is less than 63 days from the date you become eligible to enroll in the Lee County Health plan, all pre-existing conditions will be waived. HIPAA states that pregnancy will not be considered a pre-existing condition. If you have any questions regarding your rights under the COBRA and HIPAA legislation, please contact us at 239-533-2245.