Lee County Human Resources

Add or Delete Spouse/Dependent

Legible copies of these documents must be provided in order for dependents to be added to the insurance plans.

Adding Spouse or Dependent(s)

Spouse

Copies of:

- Birth certificate or driver's license or US passport
- Social security card
- Marriage certificate
- COBRA Acknowledgement Form - Spouse

Dependents

Copies of:

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

Dropping Spouse

- Copy of first and last page of final divorce decree, must be included to remove spouse.
- Letter stating gain or loss of coverage – start and end dates.

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.

The Standard Insurance Company

Lee County Board of County Commissioners
Beneficiary Designation Form

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

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

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

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

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

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

Employee Signature:	Date:

Complete form and retain a copy for your records.

The Standard Insurance Company

Remember the following when completing your Beneficiary Designation form:

- Your destination 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: Jane Smith, Spouse, 100%, **Contingent Beneficiaries:** Paul Jones, Brother, 50% Mary Park, Sister, 50%	**Primary Beneficiary:** Gayle Rich, Spouse, 100% **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.

The Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

Human Resources

The Standard Insurance Company

Lee County Board of County Commissioners - Group #164657

ADDITIONAL LIFE INSURANCE

☐ **New Hire Enrollment**

Hire Date: _____

Effective Date: _____

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

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 Life Insurance *(check all that apply).*
NOTE: If enrolling outside of new hire enrollment, Evidence of Insurability is required, as the guarantee issue amounts below do NOT apply.

☐ **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.*

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 *$25 minimum*	# Pay Periods *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)* *$3,400* **annual maximum**	**$**		**$**
☐ **Dependent Care FSA** (*out-of-pocket **day care expenses** children under age 13 or elder tax dependent for whom you are responsible)* **$***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

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) (Print EMPLOYEE'S SSN)

_____

(Print SPOUSE'S name)

Governmental Entity: (check one or indicate other)

☐ BOCC ☐ Lee County Clerk of Courts ☐ Court Administration
☐ Port Authority ☐ Tax Collector ☐ Property Appraiser
☐ Elections ☐ Other _____

_____ _____

Spouse's Signature Date

Please return this completed form to:
Lee County Human Resources
Attn: Benefits
P.O. Box 398
Fort Myers, Florida 33902