



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
- Certified marriage certificate
- COBRA Acknowledgement Form - Spouse

Dependents

Copies of:

- Birth certificate
- Social security card
- Legal Documentation for adoption, fostering, or court appointed guardianship
- Stepchildren - certified 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

☐ 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: _____

Acknowledgement Language

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 dates specified by the insurer, following approval of this application and payment of the first full premium.

Annual Plan Document Review: I acknowledge that I have received and had the opportunity to review the employer-sponsored benefit plan documents and associated guidelines for the current plan year. By signing below, I confirm that:

- I have carefully read and understood the coverage terms, benefits, deductibles, and my responsibilities under the plan.
- I have carefully read and understood the Benefit Plan Document Choice POS II and Benefit Plan Document Open Access Aetna Select exclusions, limitations, or restrictions related to surrogacy and surrogate-related services or expenses.

Plan documents can be found at <https://go.lee.fl.gov/BenefitsResourceLibrary>

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 because 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.

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 hereby 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 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%)					
1.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	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%)					
1.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	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 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: 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

To Be Completed By Human Resources

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

To Be Completed By Applicant ☐ Change in Enrollment ☐ New Hire Enrollment

Your Name (Last, First, Middle)		
Your Social Security Number	Birth Date	☐ Male ☐ Female
Your Address		
City	State	ZIP
Phone Number		
Employer Name Lee County Board of County Commissioners	Department/Entity	
Hours Worked Per Week	Earnings \$ _____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year	

Additional Life Insurance Coverage

Evidence of Insurability* is required for changes in enrollment and new hire amounts greater than guarantee issue.

Employee

- ☐ Additional Life requested amount \$ _____
 \$10,000 – \$500,000 in increments of \$1,000
 Guarantee issue amount: \$300,000

Dependents Life Insurance

- ☐ Spouse Life requested amount \$ _____
 \$10,000 – \$250,000 in increments of \$1,000
 Guarantee issue amount: \$50,000

Spouse Name _____ Date of Birth _____

Note: The coverage amount for your spouse cannot exceed 50% of your Additional Life coverage.

- ☐ Child(ren) Life requested amount \$ _____
 \$5,000 – \$25,000 in increments of \$5,000

Note: The coverage amount for your child(ren) cannot exceed 50% of your Additional Life coverage.

Refer to your certificate for the controlling policy provisions.

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. If canceling or waiving coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as waived above.

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: myeoi.standard.com/164657
 You will receive a decision directly from the carrier. Do not send health information to HR.



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



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
Port Authority
Elections

☐
☐
☐

Lee County Clerk of Courts
Tax Collector
Other _____

☐
☐

Court Administration
Property Appraiser

Spouse's Signature

Date

Please return this completed form to:

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