LEE COUNTY
SOUTHWEST FLORIDA
Board of County Commissioners
Department of Human Resources

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 Department Division	Work Phone	Home Phone

MEDICAL, DENTAL, VISION ELECTIONS

	Aetna Select	Aetna POS II	Dental	Vision Basic	Vision High
Employee Only	☐ $ 15.00	☐ $ 15.00	☐ $ 5.00	☐ $ 7.92	☐ $ 10.58
Employee & Family	☐ $160.00	☐ $160.00	☐ $40.00	☐ $ 16.68	☐ $ 22.28
Employee & Spouse	☐ $145.00	☐ $145.00			
Employee & Children	☐ $ 115.00	☐ $115.00			
Decline	☐	☐	☐	☐	☐

FAMILY INFORMATION

(Below place an "A" to Add "R" to Remove)

Last Name, First Name, MI	SSN	Date Of Birth	Relationship (S)pouse (D)ependent (G)randchild	Sex M F	Medical A R	Dental A R	VSP Basic A R	VSP High A R
Spouse								
Dependent(s) / Grandchild								

OPT OUT

WAIVER OF HEALTH INSURANCE/OPT-OUT PLAN: I understand that as an active employee, if I waive health coverage and desire to participate in the plan at a later date, I will only be able to enroll during open enrollment or if an approved qualifying event occurs and I enroll within 60 days of the qualifying event and provide proof of previous coverage.

☐ I wish to **PARTICIPATE** in the Opt-Out Plan and have attached proof of other medical coverage.

☐ I wish to **DISCONTINUE** my participation in the Opt-Out Plan and have re-enrolled in the medical plan indicated above.

OTHER INSURANCE

Is your Spouse Employed? ☐ Yes ☐ No	If yes, please give name and address of spouse's employer.
Does your spouse have health insurance? ☐ Yes ☐ No	If yes, please give name and policy number of insurance carrier or other HMO. If yes, who is covered by this policy? ☐ Yourself ☐ Yourself/Spouse ☐ Spouse only ☐ Entire Family

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 change in family status. NOTE: IMPORTANT INFORMATION ON THE BACK, YOU ARE AUTHORIZING A RELEASE OF YOUR MEDICAL INFORMATION. PLEASE READ AND REVIEW.

______________________ ______________________ ______________________

SIGNATURE **PRINTED NAME** **DATE**

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, any and 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 make adjustments to 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.

IMPORTANT INFORMATION: Evidenced by my signature on the other side, I affirm that all information is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my dependents' and/or my coverage. 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.