BENEFITS ADMINISTRATION DIVISION
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FOR OFFICE USE ONLY
Transmitted: _____
Entered: _____

Enrollment/Change Form - Active Employees

NAME: _____EMPLOYEE ID# _____ or SS# XXX-XX- _____ DATE OF BIRTH _____

STREET: _____CITY/STATE: _____ZIP:_____

PHONE-WORK: _____ HOME: _____ DEPT: _____ DATE OF HIRE: _____

REASON: _____ NEW EMPLOYEE _____ OPEN ENROLLMENT STATUS CHANGE: _____
TYPE OF CHANGE DATE OF EVENT

STEP 2 – Put an X by the Health Coverage in which you want to enroll. NOTE: LTGF Employees may only elect medical coverage.

MEDICAL COVERAGE	DENTAL COVERAGE
Medical Provider _____ HMO _____ PPO	_____ PPO _____ DMO (Must complete provider form to select dentist)
_____Individual _____Two-Person _____Family _____No Coverage	_____Individual _____Two-Person _____Family _____No Coverage

MEDICAL OPT OUT CREDIT	PRESCRIPTION OPT OUT CREDIT
_____Opt Credit ($400) – Proof of Coverage Required Must Be Renewed Annually	_____Opt Credit ($200) – Must Be Renewed Annually

VISION	PRESCRIPTION
_____ BASE PLAN _____ BUY-UP PLAN _____Individual _____Two-Person _____Family _____No Coverage	_____Individual _____Two-Person _____Family _____No Coverage

STEP 3 — Complete this section and mark an X for each plan you elect for you and the dependents you will cover. To DROP a dependent, list name and mark the 'drop' box with an "X".

Full Name (PRINT) First MI Last	Drop	Relationship	Sex	SSN	Birth Date	Medical	RX	Vision	Dental

FOR STEPS 4 through 6: Unless you are a new employee, you are required to complete an Evidence of Insurability Form.

STEP 4 - EXTRA LIFE INSURANCE - Complete this section to INCREASE, CHANGE or DROP your life insurance. The Extra Life Insurance is IN ADDITION to the 2 times your annual salary of Basic life insurance provided by the County. Rates will increase based on salary and age.

_____Additional 1X Base Pay ____Additional 2X Base Pay ____Additional 3X Base Pay ____Additional 4X Base Pay _____Drop Extra Life Insurance

STEP 5 – DEPENDENT SPOUSE LIFE INSURANCE - Complete this section to ENROLL, CHANGE or DROP the Dependent Spouse Life Insurance Plan. Employees must be enrolled or applying for Extra Life Insurance in order to enroll in Dependent Life Insurance. Spouse Life Insurance rates increase based on employee age.

____ $10,000 Coverage _____ $25,000 Coverage _____ $50,000 Coverage _____ Drop Dependent Spouse Life Insurance

STEP 6 – DEPENDENT CHILD LIFE INSURANCE - Complete this section to ENROLL, CHANGE or DROP the Dependent Child Life Insurance Plan. Employees must be enrolled or applying for Extra Life Insurance in order to enroll in Dependent Life Insurance.

____ $5,000 Coverage _____ $10,000 Coverage _____ $20,000 Coverage ____Drop Dependent Child Life Insurance

STEP 6 – Long-Term Disability - Complete this section to ENROLL, CHANGE or DROP the Long-Term Disability coverage.

_____50% Base pay after 180 days _____60% Base pay after 180 days _____DROP Long-Term Disability Coverage

STEP 7 – Short-Term Disability - Complete this section to ENROLL, CHANGE or DROP the Long-Term Disability coverage.

_____up to 60% of your salary (Maximum $3,000 weekly benefit) _____DROP Short-Term Disability Coverage

STEP 8- FLEXIBLE SPENDING ACCOUNTS - Complete this section to ENROLL or RENEW the Flexible Spending Accounts. Employee must renew enrollment EACH plan year and indicate Annual Amount.

Health Care Flexible Spending Account	Dependent Care Flexible Spending Account
Annual Amount_____	Annual Amount_____

STEP 9 - Read the statement below and sign your name.
By signing this form, I understand that my premiums will be deducted on a pre-tax basis, except for Extra Life Insurance, Dependent Life Insurance, Short-Term Disability, and Long-Term Disability. No changes can be made during the plan year unless there is a qualified status event and I complete a benefits enrollment form within 30 days of the event. This form authorizes any licensed physician, hospital or health care provider to furnish my health plan with such medical information about myself and any eligible dependent, as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

_____ _____
Signature Date