PINELLAS COUNTY GROUP INSURANCE

Please type or print firmly with black ink.
Read instructions & important information on reverse.

□ **NEW ENROLLMENT** □ **ANNUAL ENROLLMENT** □ **CHANGE**

For Internal Use Only

PERSONAL INFORMATION					Division
Last Name	First Name		Middle Initial		Employee #
Mailing Address			Apt. Number		Coverage Effective Date
City	State		Zip Code		Payroll Effective Date
Home Phone	Work Phone	Date of Birth	Gender	Social Security No.	No Premium Change □ Health □ Dental

PRE-TAX CONTRIBUTIONS Department of Treasury Federal Regulations permits health/dental contributions to be deducted from your gross pay *before taxes* resulting in less tax liability. □ **YES, I want this tax savings option.** □ **NO, I DO NOT want this tax savings option.**

HEALTH PLAN	**Type of Coverage**		**DENTAL PLAN**	**Type of Coverage**
□ **Choice Plus POS**	□ Employee	Do any members listed have other health	□ **Cigna Reimbursement**	□ Employee
□ **Choice Plus HRA**	□ Employee + Spouse	health insurance and/or Medicare?	□ **Safeguard**	□ Employee + 1
□ **Choice Plus HSA**	□ Employee + Child(ren)	□ No □ Yes	□ **Decline**	□ Employee + 2 or more
□ **Opt Out**	□ Family	Name of Plan ____________________		
□ **Decline**				

√ if applicable Health	Dental	Last Name First Name MI	Relationship	Gender M	F	Date of Birth	Social Security #	Safeguard ID
□	□	Same as above	Employee					
□	□		Spouse	□	□			
□	□			□	□			
□	□			□	□			
□	□			□	□			
□	□			□	□			
□	□			□	□			
□	□			□	□			

LIFE INSURANCE Pre-tax not applicable.

Employee Basic Life coverage for 1x annual salary is provided by the County.
□ Employee Supplemental Life $____________________
(Must be multiples of $5000, not to exceed 5x annual salary or $250,000)

Optional Dependent Life (Employee is beneficiary)
□ Spouse $10,000 and Child(ren) $5,000 per child
□ Spouse $20,000 and Child(ren) $10,000 per child

Beneficiary Name(s) for Employee Basic/Supplemental Life Insurance	Relationship	Address (if known)

CHANGES

- □ Change name to that shown above. My former name was:____________________
- □ Change address to that shown above. You must also notify your department.
- □ Remove members listed above under the following coverage: □ Health □ Dental
- □ Add members listed above under the following coverage: □ Health □ Dental
- □ Correct members information as shown above.
- □ Change health coverage to: □ Emp □ Emp + Spouse □ Emp + Child(ren) □ Family
- □ Change dental coverage to: □ Emp □ Emp + 1 □ Emp + 2 or more
- □ Change from Division ____________________ to Division____________________
- □ Cancel Supplemental Life □ Cancel Dependent Life □ Cancel WRAP Plan □ Cancel LTD

Reason (see reverse for required documentation)
Date of Change ____________________
- □ **Marriage** □ **Divorce**
- □ **Deceased**
- □ **Birth of Child/Adoption/Legal Custody**
- □ **Ineligible** □ **Student Status/Age Limit**
- □ **Began/Left Employment**
- □ **Change in Residence**
- □ **Attained Age 65**
- □ **Other** ____________________

The information provided above is true and correct to the best of my knowledge. I understand & accept the provisions on the reverse side of this form.

Signature	Date Signed

(FOR INTERNAL USE ONLY) TERMINATION

	Life	**Disability**	**FSA**	**Reason for Termination:**		
□ Health	□ Basic	□ County Paid LTD	□ Health Care Acct	□ Deceased	□ Left Employment	□ Reduction in Hours
□ Dental	□ Supplemental	□ Employee Paid LTD	□ Dependent Care Acct	□ Inactive Service	□ Opt Out	□ Retirement
□ Opt Out	□ Dependent			□ Other/Comments: ____________________		
□ Decline	□ WRAP Plan	____________________				

INSTRUCTIONS

New Enrollment: Check *New Enrollment*, complete Personal Information, all the enrollment sections of the form; sign and date.
Annual Enrollment: Check *Annual Enrollment*, complete Personal Information and all sections related to the changes you are making; sign & date.
Change: For changes outside of Annual Enrollment, check *Change*, complete Personal Information & complete all sections related to change, sign & date.

PROVISIONS

By signing this form, you are authorizing deductions from your earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required. Benefits for which you will be eligible are in accordance with the terms of the Certificate of Coverage.

DOCUMENTATION REQUIREMENTS FOR COVERAGE CHANGES

After initial enrollment in the plan, changes are permitted during the County's annual enrollment period. If you elect to have your premium contributions deducted on a pre-tax basis, changes at any other times may be made only for certain change of status events as shown below, and only if your request and any required supporting documentation is received in Employee Benefits no later than 31 days after the status event. If you have not elected pre-tax deductions many of the same requirements are contained in the group health and dental plan. The information on this page is a summary. Please refer to the group plan description and/or the pre-tax plan for detailed information.

- **Change In Legal Marital Status.**
  Copy of marriage certificate, divorce decree or death certificate must be attached.
- **Change In The Number Of Dependents** (including birth, adoption or placement for adoption, or death of a dependent).
  Copy of birth certificate, death certificate, court order of legal custody or other documentation is required.
- **Change In Employment Status** (resulting in gain or loss of eligibility for coverage for an employee, spouse or dependent).
  Copy of COBRA or HIPAA notice or letter from employer must be attached stating date eligibility and/or coverage will begin/cease must be attached.
- **Dependent Satisfies (Or Ceases To Satisfy) Dependent Eligibility Requirements.**
  Written documentation may be required including but not limited to certifications of financial dependency, proof of student status, court orders or other legal documents must be attached.
- **Change In Residence** (Outside Of Network Area). Must result in an individual gaining or losing eligibility.
  Written documentation must be provided.
- **Other**: Explain and provide supporting documentation.

DEPENDENT ELIGIBILITY (as defined in the health plan descriptions)

Dependent – the Employee's legal spouse or an unmarried dependent child of the Employee or the Employee's spouse. The term child includes any of the following:

Natural child.	Foster child.
Stepchild.	Child placed for adoption.
Legally adopted child.	Child for whom legal guardianship has been awarded to the Employee or the Employee's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

A Dependent includes any unmarried dependent child under 19 years of age.
A Dependent includes an unmarried dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:

- The child must be a full-time or part-time student; or
- The child must reside in the Employee's household.
- The child must be primarily dependent upon the Employee for support and maintenance. We have the right to request proof of the child's dependency status at any time.

Note: Dependent is eligible for coverage until the end of the calendar year in which the Dependent reaches a limiting age.

The Employee must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

SPECIAL CONDITIONS FOR "OPT OUT" OF HEALTH PLAN

- By selecting "Opt Out", you are requesting termination of County Health Plan benefit coverage, including mental health, pharmacy and vision benefits, and instead are electing to receive a monthly cash subsidy towards the purchase of other benefits, including your health care costs incurred from another carrier with whom you are currently enrolled.

- You must submit a copy of the front and back of your current medical identification card as proof of other coverage. The County may request proof of continued coverage at any time and failure to provide this information will void the monthly cash subsidy.

- If your termination of coverage is due to a change in family status, or non-voluntary termination of coverage, you may immediately forfeit your health care subsidy and enroll under the County's plan. If you voluntarily terminate the coverage for other reasons, you forfeit your health care subsidy and may not apply to enroll under the County's plan until the following plan year.

- Only permanent full time employees are eligible for the "Opt Out" cash subsidy. Medicare, Medicaid and other government funded programs are not considered alternate coverage for the purposes of this benefit.