Beneflex Insurance Enrollment & Change Form 2018

Risk Management & Insurance
301 4th St. SW, Largo, FL 33770
(727) 588-6197 Fax (727) 588-6182

Reason for Application: Please check appropriate box and read required documentation needed. Please read, complete and sign all four pages.

New Hire ☐	REQUIRED SUPPORTING DOCUMENTATION (If you are enrolling members in insurance coverage)
Spouse	Copy of marriage certificate
Child(ren)	COPY of birth certificate or adoption documentation. Court ordered legal custody documentation
Disabled Child(ren)	COPY of birth certificate AND COPY of most recent tax return confirming child is your dependent.
Unmarried Child(ren) Age 26-30 (Health only)	COPY of birth certificate AND document dated within the last 60 days showing Florida residency or COPY of the current enrollment schedule to confirm status as either a full or part time student.

If you are a new hire, you must complete this form and submit within 31 days of your hire date. If you are experiencing an IRS recognized family status change, you must complete this form and submit within 31 days of the life event. Changes are effective the first of the month following event date and receipt of application, unless otherwise stated.

FAMILY STATUS CHANGE LIFE EVENT ☐	REQUIRED SUPPORTING DOCUMENTATION – *Contact Risk Management if you are unable to provide documentation with application submission. Birth certificates for newborns may be sent after enrollment & change form is received, if unavailable at time of submission.
Marriage	COPY of Marriage certificate
Birth/Adoption	COPY of Birth Certificate(s) *or adoption documentation Court ordered Legal Custody documentation
Divorce	COPY of first and last page of final divorce decree
Loss of Coverage	Documentation from employer or insurance provider indicating WHO lost coverage, WHEN coverage ended and WHY coverage ended. Loss of coverage must be because you are no longer eligible versus voluntary cancellation of coverage or for non payment.
Obtained Coverage	Documentation that you or your dependent has obtained other coverage. Documentation should include WHO has obtained coverage and the effective date of coverage.
Other	Please contact Risk Management for required documentation.

Annual Enrollment ☐	

Please Check BENEFICIARY CHANGE ONLY ☐	Complete Top Employee Information section, Life Insurance Beneficiary section, and Signature with Date.

Interactive Form available online at http://www.pcsb.org/ *Go to Central Printing Services,PCS Form number 3-2247-C18*

FOR OFFICE USE ONLY

Effective Date: / /

PINELLAS COUNTY SCHOOLS

BENEFLEX INSURANCE ENROLLMENT AND CHANGE FORM 2018
EMPLOYEE

Print or Type Clearly.Use Black Ink.

NAME (Last, First, M.I.)				SOCIAL SECURITY LAST FOUR DIGITS / / /
ADDRESS (No., Street)	CITY	STATE	ZIP CODE	HOME PHONE
SEX	DATE OF BIRTH / /	EMPLOYMENT DATE / /	POSITION	SCHOOL/DEPARTMENT	WORK PHONE

Rates Listed are Per-Pay Deductions for 20 Pay Periods

1. HEALTH ❑ **REFUSAL**

	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE & CHILDREN	2 BOARD EMPLOYEES + CHILD(REN)	SPOUSE OF 2 BOARD
• **HMO STAFF** (Physician I.D. # required)	❑ 77.00	❑ 207.00	❑ 192.00	❑ 276.00	❑ 181.00	❑ No charge
EE Physician I.D. # _____						
• **NATIONAL POS OPEN ACCESS**	❑ 86.00	❑ 226.00	❑ 211.00	❑ 314.00	❑ 219.00	❑ No charge
• **CONSUMER DIRECTED HEALTH PLAN (CDHP)**	❑ 58.00	❑ 169.00	❑ 154.00	❑ 223.00	❑ 128.00	❑ No charge

2. DENTAL ◆ ❑ **REFUSAL**

	EMPLOYEE	EMPLOYEE + 1	EMPLOYEE +FAMILY	2 BOARD EMPLOYEES + CHILD(REN)	SPOUSE OF 2 BOARD
• **HUMANA ADVANTAGE DENTAL**	❑ 7.02	❑ 13.02	❑ 19.03	❑ 17.03	❑ No charge
• **METLIFE PDP**	❑ 12.46	❑ 23.06	❑ 33.28	❑ 31.28	❑ No charge

3. EYE MED VISION ◆ ❑ **REFUSAL**

❑ EMPLOYEE	❑ EMPLOYEE + 1	❑ EMPLOYEE +FAMILY
No Cost	2.83	5.92

4. MET LIFE HOSPITAL INCOME PLAN ◆ ❑ **REFUSAL**

❑ EMPLOYEE	❑ EMPLOYEE + SPOUSE	❑ EMPLOYEE + CHILDREN	❑ EMPLOYEE + FAMILY
8.00	13.00	17.00	$21.00

DEPENDENT INFORMATION

Please list each family member below that you wish to ENROLL IN OR DELETE FROM MEDICAL, DENTAL, VISION OR HIP

❑ **Add** ❑ **Delete** **See additional dependent criteria regarding this section.**

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SSN	GENDER	BIRTHDATE	MED	DEN	VIS	HIP	HMO PHYSICIAN ID #
							❑	❑	❑	❑	
							❑	❑	❑	❑	
							❑	❑	❑	❑	
							❑	❑	❑	❑	
							❑	❑	❑	❑	

5. ACCIDENTAL DEATH & DISMEMBERMENT ◆ ❑ **REFUSAL**

	EMPLOYEE	EMPLOYEE + FAMILY
$50,000	❑ .60	❑ 1.05
$100,000	❑ 1.20	❑ 2.10
$200,000	❑ 2.40	❑ 4.20
$300,000	❑ 3.60	❑ 6.30

6. SHORT TERM & LONG TERM DISABILITY INCOME PROTECTION ◆ ❑ **REFUSAL STD** ❑ **REFUSAL LTD**

❑ New Coverage; Complete Sunlife Application

❑ Change in Benefit; Complete Sunlife Application

7. FAMILY TERM LIFE ❑ **REFUSAL**

❑ $.90 - I wish to enroll all eligible dependents for one premium amount

8. HEALTH CARE REIMBURSEMENT ACCOUNT ◆ ❑ **REFUSAL**

Please DEDUCT $_____ PER PAYCHECK (Minimum deduction of $10 - all deductions must be in whole dollars, not to exceed $2500 per calendar year.)

9. DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT ❑ **REFUSAL**

Please DEDUCT $ _____ PER PAYCHECK (Minimum deduction of $10 - all deductions must be in whole dollars, not to exceed $5,000 per calendar year.)

10. OPTIONAL TERM LIFE ❑ **REFUSAL**

Employee *Guaranteed* Issue - New Hire Only

❑ 10,000 ❑ 20,000 ❑ 30,000 ❑ 40,000 ❑ 50,000

❑ 60,000 ❑ 70,000 ❑ 80,000 ❑ 90,000 ❑ 100,000

❑ EE VTL >$100,000 - online application required

❑ SP VTL up to $100,000 - online application required

❑ CH __2,000__ 4,000__ 6,000__ 8,000__ 10,000

Pre Tax Premium Plan – By signing below I elect to have premiums for my medical, dental, vision, HIP, disability and flex-spending account(s) deducted from my pay on a pre-tax basis. Premiums will continue unless noted otherwise.

Insurance Premiums – Premiums are due in advance, therefore deductions begin the month before the effective date of coverage. Deductions are taken over 20 pay periods. I understand that I pay for coverage over a 10 month period, but I am covered for the entire year. Premium for summer coverage may be an additional amount owed upon initial enrollment or if a change is made during the year.

Signature_____ E-Mail Address _____ Date _____

◆ **Eligible for "No Health – Board Contribution"**

BENEFICIARY INFORMATION
Board paid Life Insurance and AD & D Beneficiary(ies) -Required Information

Your **primary beneficiary** is first in line to receive your death benefit. If the **primary beneficiary** dies before you, a **secondary** or **contingent beneficiary** is the next in line. Percentages must equal 100%

PRIMARY

BENEFICIARY NAME	RELATIONSHIP	ADDRESS	BIRTHDATE	%*

*Total Must Equal 100%

SECONDARY (optional)

BENEFICIARY NAME	RELATIONSHIP	ADDRESS	BIRTHDATE	%*

*Total Must Equal 100%

PATIENT PROTECTION AND AFFORDABLE CARE ACT INFORMATION

The Affordable Care Act requires most Americans to purchase health insurance coverage or pay a penalty. The medical plan offered by PCS meets the affordability and coverage requirements.
If you enroll in a PCS-sponsored medical plan, you will not pay a penalty.
If you are offered health coverage through PCS, you will not be eligible for a premium subsidy through the Federal Marketplace.

- If you receive a premium subsidy, and you are insurance benefit eligible you may be responsible to pay the premium subsidy back to the IRS.
- Your spouse and your children must also have health insurance coverage cannot afford to enroll your spouse and/or child(ren) in a PCS medical plan, there may be cost-effective options through the Federal Marketplace and/or Florida KidCare.
  If you choose to opt out of PCS coverage and buy insurance in the Marketplace, you will:
- Not receive a contribution from PCS toward the cost of your Marketplace coverage.
- Not be eligible for a government premium subsidy to help pay for your Marketplace coverage.
- If you receive a premium subsidy, and you are insurance benefit eligible you may be responsible to pay the premium subsidy back to the IRS.

REFUSAL OF HEALTH COVERAGE

I acknowledge that I have been offered the opportunity to purchase affordable and comprehensive health coverage from Pinellas County Schools for myself and my eligible dependents.

I do not wish to enroll myself or any dependents in any type of medical coverage at this time.

I have other medical coverage provided by: _____
Name of Insurance Company/Employer

I understand that I will not be able to enroll in coverage or make changes to my election until the next annual enrollment period, or within 31 days of a qualified change in status (loss of group coverage, marriage, divorce, birth of a child, adoption of a child).
I understand that I must notify Risk Management & Insurance in writing within 31 days of the qualified change in status (life event).

_____ _____
Printed Name Date

_____
Signature

Dependent Verification

If you are requesting enrollment of a spouse or dependent child, please **confirm that all of your dependents meet the eligibility requirements** and **provide us their social security numbers. This is required to comply with Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Payer program.**

MEDICAL, DENTAL, VISION COVERAGE

Eligible dependents include :

- Your **legally married** spouse
- Your natural born child, step-child, foster child, legally adopted child, or child placed in your custody for adoption whose age is less than the limiting age.
- A newborn child of a covered dependent may be covered while the parent is an eligible dependent under the plan up to the limiting age of 18 months. Grandchildren may also be covered if he or she is dependent upon you for support and you have court-ordered "legal custody" - Documentation will be required.

Age Limits:

- For medical, dental, and vision coverage, your children may be covered up to the end of the calendar year in which they attain age 26. No additional dependent financial or student status is required.
- For medical coverage only, adult children beyond age 26, and who have reached the limiting age, may apply for continuous coverage **up to the end of the calendar year in which he or she turns 30.** Deductions will occur post-tax.

  Adult children must:

  1. Be unmarried and have no children of his or her own
  2. Be a resident of the state of Florida or a full-time or part-time student, and
  3. Have no medical insurance as a named subscriber, insured enrollee, or covered under any other group or individual Insurance plan; or not be entitled to benefits under Social Security and/or Medicare.
- Handicapped children may be covered beyond limiting age, if proof of handicapped status is provided to Risk Management within 31 days of the limiting age. See Beneflex guide for full details.

LIFE INSURANCE COVERAGE

Eligible dependents include

- Your legally married spouse, up to age 70
- Dependent children include your unmarried natural born child, step-child, foster child, child proposed for adoption, and child for whom you have been appointed legal guardian. Your dependent will be covered to the end of the calendar year in which he or she turned 26.
- Grandchildren may only be covered if you have court-ordered "legal custody."

Please verify whether you have read and understand the dependent eligibility criteria above. If a dependent is listed that does not meet this criteria, you may be responsible for reimbursing the insurance carrier for all claims and repaying the district for its premium contribution for up to 12 months. Enrolling dependents who are not eligible under PCS plans, may also subject you to disciplinary action. In addition to our internal policies, the Florida Department of Financial Services views this activity as fraud and considers it prosecutable under the law.

_____ _____

Print Name **Date**

_____

Signature

Return form(s) within 31 days of your hire date or family status change to:

PCS Risk Management & Insurance

Fax (727) 588-6182

Please keep a copy for your records.