Beneflex Insurance Enrollment & Change Form 2020

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

New Hire	REQUIRED SUPPORTING DOCUMENTATION (If you are enrolling members in insurance coverage)
Spouse	COPY of marriage certificate or the first page of your most recent tax return with your spouse's name.
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.

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 or 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-C19*

FOR OFFICE USE ONLY

Effective Date: / /

PINELLAS COUNTY SCHOOLS

BENEFLEX INSURANCE ENROLLMENT AND CHANGE FORM 2020

EMPLOYEE

Print or Type Clearly.Use Black Ink.

NAME (Last, First, M.I.)				SSN 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. MEDICAL __ REFUSAL	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE & CHILDREN	2 BOARD EMPLOYEES + CHILD(REN)	SPOUSE OF 2 BOARD
• **AETNA Select Open Access**	__ 81.00	__ 218.00	__ 199.00	__ 288.00	__ 198.00	__ No charge
• **AETNA CHOICE POS II**	__ 90.00	__ 238.00	__ 219.00	__ 327.00	__ 237.00	__ No charge
• **AETNA CDHP (Consumer Directed Health Plan)**	__ 62.00	__ 178.00	__ 159.00	__ 233.00	__ 143.00	__ 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**	__ 13.57	__ 24.98	__ 36.06	__ 34.06	__ 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
							❑	❑	❑	❑
							❑	❑	❑	❑
							❑	❑	❑	❑
							❑	❑	❑	❑
							❑	❑	❑	❑

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. DISABILITY PLAN ◆ __ REFUSAL

SEPARATE APPLICATION REQUIRED

__ Plan 1 (2YRS)

__ Plan 2 (to SSNRA)

7. FAMILY TERM LIFE __ REFUSAL

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

FLEXIBLE SPENDING ACCOUNTS

8. HEALTH CARE FLEXIBLE SPENDING ◆ __ REFUSAL

Deduction per paycheck $ _____ Minimum deduction $10.
Must be in whole dollars. May not exceed $2,700 per calendar year.

9. DEPENDENT CARE FLEXIBLE SPENDING __ REFUSAL

Deduction per paycheck $ _____ Minimum deduction $10.
Must be in whole dollars. May not 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

__ **Employee Election over $100,000** requires separate application subject to medical approval

__ **Spouse Optional Term Life** requires separate application - may elect up to $100,000 not to exceed employee election

__ **Children Optional Term Life**
__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

Name _____ **SSN Last 4 Digits**_____

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%**

Signature _____ **Date**_____

PATIENT PROTECTION AND AFFORDABLE CARE ACT INFORMATION

Starting in 2019, most Americans are no longer required to purchase health insurance coverage or pay a penalty. However, whether you are eligible for a premium subsidy depends on the plan offered by your employer. The medical plan offered by PCS does meet the affordability and coverage requirements.

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 benefits eligible you may be responsible to pay the premium subsidy back to the IRS.
- If you cannot afford to enroll your spouse and/or child(ren) in a PCS medical plan, there may be cost-effective options through the 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 towards 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 medical coverage at this time.

❑ 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).

_____ _____

Signature Date

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, child placed in your custody for adoption, or child for whom you have been appointed permanent legal guardian, 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 eligible 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.
- 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.
- Children for whom you had permanent legal guardianship or foster children - typically once they turn 18 are no longer eligible.

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, legally adopted child, child proposed for adoption, or child for whom you have been appointed legal guardian, whose age is less than the limiting age. Your eligible 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.