PINELLAS COUNTY SCHOOLS
STATEMENT OF BENEFITS

EMPLOYEE NAME:_____ LAST 4 DIGITS OF SSN:_____

SCHOOL/DEPT:_____ POSITION: _____ REHIRE: Y __ / N __

ENROLLMENT FORMS DUE DATE: ***31 Days from Date of Hire***

INSURANCE EFFECTIVE DATE*: ***First of month following 60 days in an eligible status*** ***(see New Hire Insurance Date Chart)***

Risk Management & Insurance is responsible for the administration of the Employee Benefit Program for Pinellas County Schools. We are located in the School Board Administration Building.

Below you will find **important** information concerning your Employee Benefits Program. Please read it carefully and if you have any questions or need assistance in completing your enrollment forms, please **contact Risk Management at 588-6197**.

Refer to **www.pcsb.org/new-hire** for the following:

New Hire Decision Guide

Benefit Enrollment forms

New Employee Orientation Presentation Video

I have received information and enrollment forms relative to the insurance benefits provided by Pinellas County Schools. I understand it is **my** responsibility to read the information, complete all the required enrollment forms and ensure that the forms are **received** by Risk Management by the Enrollment Due Date (not to exceed 31 days from date of hire or a change in status).

I understand if I fail to complete and/or submit the enrollment forms by the due date, I may not be eligible to enroll in insurance benefits until the next designated annual enrollment period or within 31 days of a qualified family status change.

*New Hires

I understand my benefits are effective first of the month following 60 days of employment in a benefit eligible status and receipt of my enrollment forms by Risk Management.

*Re-Hires

If you have been rehired within 6 months, and were previously benefit eligible, your benefits will be effective first of the following month after receipt of paperwork, and your waiting period may be reduced. However, benefits may not be effective any later than the first of the month following 60 days of employment.

I understand if my coverage is effective after January 1, I may be responsible for summer premiums that will automatically be withheld from my paycheck in addition to my normal bi-weekly deductions. If payroll deduction is not available, I agree to pay all premiums due for the benefits plans I have selected.

I understand I am enrolled in my benefit plans on a pre-tax basis for the calendar year and that I can **only** make benefit changes if I experience a qualified life event. Refer to Beneflex Guide for a list of qualifying events. Documentation will be required.

I further understand I must submit an Enrollment and Change Form to change any benefit (with appropriate documentation) and that it **must** be received by Risk Management within **31 days** of the occurrence of the event.

I acknowledge information concerning my rights under the Consolidated Budget Reconciliation Act (COBRA) has been made available to me (**pcsb.org/cobra**) and I understand if married, it is my responsibility to share this information with my spouse and/or dependents. **(Spouse must sign below.)**

I have received information about my rights and responsibilities regarding work related illness or injuries under Workers Compensation. I understand that 1) it is my responsibility to report a work related accident within 24 hours, when possible; 2) unauthorized absences and treatment will not be covered and 3) Pinellas County Schools has the right to choose the medical providers who will treat me. Full details available online: **pcsb.org/workerscomp**.

_____ _____

Employee Signature Date

___I am not married.

_____ _____

Spouse Signature Date

Return White Copy to – Risk Management Yellow – Employee Copy

The Pinellas County Schools' Employee Benefit Program is subject to change at anytime as determined by the insurance carrier and Benefit Plan Administrator.