HERNANDO COUNTY SCHOOL DISTRICT
ELECTION CONFIRMATION AND ENROLLMENT FORM
FOR PLAN YEAR JANUARY 1, 2021 – DECEMBER 31, 2021

Employee's Name – Last, First, MI	Sex	Soc. Sec. #	Date of Birth
Street Address		Phone Number ( ) -	Coverage/Change Effective Date
City	State	ZIP	Marital Status (married, divorced, single, widowed) -
Place of Work	Employee #	Position	Hired/Start Date

NOTE: Premiums listed reflect amount deducted per pay check for 24 deductions per year. 180/185 day employees (Bus Drivers, etc.) will have a prorated amount that will be deducted via 20 checks. Employees with 20 deductions may request an election form with prorated amounts.

New Hire benefits are effective the first of the month following a 60 day waiting. This election form revokes any prior election form and will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of an consistent with a qualified event as outlined in the District's Section 125 Qualifying Event Checklist.

SIGNATURE: _____ **DATE:** _____

FLORIDA BLUE HEALTH INSURANCE

_____**Initial if you do not want to participate.**

_____**Initial if you want to drop or change your existing health coverage. (Complete Page 2)**

_____**Initial to make the following elections. (Complete Page 2)**

BLUE CARE HMO #60 010110 District Contribution $275.36 Per Pay				BLUE CARE HMO #54 010110 District Contribution $275.36 Per Pay				BLUE OPTIONS #05770 010800 District Contributions $275.36 Per Pay			
Coverage Level	Per Pay Ded	Per Pay MLR Contr	Initial	Coverage Level	Per Pay Ded	Per Pay MLR Contr	Initial	Coverage Level	Per pay Ded	Per Pay PS Contr	Initial
Emp Only	103.62	10.75		Emp Only	48.84	10.75		Emp Only	78.91	10.05	
Emp+Sp	445.78	20.46		Emp+Sp	341.53	20.46		Emp+Sp	402.82	19.24	
Emp+Chn	380.33	18.60		Emp+Chn	285.39	18.60		Emp+Chn	343.98	17.57	
Emp+Fam	754.50	29.22		Emp+Fam	605.63	29.22		Emp+Fam	695.49	27.54	
2EmpFam	479.14	29.22		2EmpFam	330.27	29.22		2EmpFam	420.13	27.54	

☐ Covered under spouse via 2 Emp. Fam. (60 – 011110; 05770 – 010810) – SS#_____

FLORIDA COMBINED LIFE DENTAL

_____**Initial if you do not want to participate.**

_____**Initial if you want to drop or change your existing dental coverage. (Complete Page 2)**

_____**Initial to make the following elections. (Complete Page 2)**

Blue Dental Choice PPO Copay Plan

- ☐ 030037 Employee Only $ 8.74
- ☐ 030038 Employee + 1 $16.84
- ☐ 030039 Employee + 2 or more $26.74

Blue Dental Choice PPO Coinsurance Plan

- ☐ 030024 Employee Only $14.52
- ☐ 030025 Employee + 1 $27.97
- ☐ 030026 Employee + 2 or more $44.41

HUMANA VISION PLAN

_____**Initial if you do not want to participate.**

_____**Initial to drop or change your existing vision coverage. (Complete Page 2)**

_____**Initial to make the following elections. (Complete Page 2)**

☐ 040101 Employee Only $3.11 ☐ 040102 Employee + 1 $6.97 ☐ 040103 Employee + Family $9.61

GROUP LIFE INSURANCE

_____**Initial to make the following life insurance election. (Complete Page 2)**

☐ 020102 I have selected health insurance, thus my employer paid life option is $10,000 (*020105 reduced by 50% at 70 yoa)*

☐ 020103 I have not selected health insurance, thus my employer paid life option is $30,000 (*020106 reduced by 50% at 70 yoa)*

☐ 020104 I wish to add dependent life ($5,000 – spouse, $2,500 – child, $500 14 days-6 months) at my expense of $1.13 per pay

Reimbursement Accounts, Cancer Protection and Disability Income Protection and Additional Benefits

_____ **Initial to confirm** that you have received information & that you understand that you must contact the vendor representative to enroll in Reimbursement Accounts, Cancer Protection, Disability Income Protection etc.

HERNANDO COUNTY SCHOOL DISTRICT
ELECTION CONFIRMATION AND ENROLLMENT FORM
FOR PLAN YEAR JANUARY 1, 2021 – DECEMBER 31, 2021

Dependent Information

A/D Add/Delete	Last Name, First Name (if different)	Sex	Social Sec #	Date of Birth	Relation to you	Physician Name (HMO Only)	Existing Patient (Y/N)	Coverage (Health, Dental, Vision)

Concurrent Coverage Information

Complete the following only if you or your dependents currently have other health coverage; i.e. spousal group, Medicare, which will be in effect at the same time as the District insurance and for which you are requesting coordination of benefits.

Other Health Carrier Name:	Contract #:	Effective Date:
List names of all family members that are covered, including yourself:		

Beneficiary Information

Last Name, First Name, MI	Date of Birth	Relation to you	% of Share
Primary Beneficiary:			
Primary Beneficiary:			
Primary Beneficiary:			
Primary Beneficiary:			
Secondary (Contingent) Beneficiary			
Secondary (Contingent) Beneficiary			

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SIGNATURE: _____ **DATE:** _____

Mid-year changes are allowed when gaining or losing coverage through a spouse's employer, your former employer, or one of the federal or state sponsored insurance plans (i.e. COBRA, military, Medicare, Medicaid, SSA, Veteran's Administration). Mid-year changes are not allowed for a voluntary drop of coverage. Changes due to employment are retroactive to the date of loss/gain of coverage. Changes due to the birth of a child are retroactive to the date of birth. **CHANGES REQUESTED MUST BE SUBMITTED WITHIN 30 DAYS OF THE QUALIFYING EVENT.**