HERNANDO COUNTY SCHOOL DISTRICT
ELECTION CONFIRMATION AND ENROLLMENT FORM
FOR PLAN YEAR JANUARY 1, 2025 – DECEMBER 31, 2025

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 paycheck for 24 deductions per year.

New Hire benefits are effective the first of the month following a 60-day waiting period. 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 and 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)

□ Covered under spouse via 2 EmpFam (60 & 54 – 011110; 05770 – 010810) – SS#_____

BLUE CARE HMO #60 010110 District Contribution $392.22 Per Pay				BLUE CARE HMO #54 010110 District Contribution $392.22 Per Pay				BLUE OPTIONS #05770 010800 District Contributions $392.22 Per Pay			
Coverage Level	Per Pay Ded	Per Pay MLR Contr	Check Election Below	Coverage Level	Per Pay Ded	Per Pay MLR Contr	Check Election Below	Coverage Level	Per pay Ded	Per Pay PS Contr	Check Election Below
Emp Only	101.19	0		Emp Only	31.83	0		Emp Only	69.03	0	
Emp+Sp	531.44	15.23		Emp+Sp	399.46	15.23		Emp+Sp	475.51	15.23	
Emp+Chn	447.15	14.30		Emp+Chn	326.96	14.30		Emp+Chn	399.84	14.30	
Emp+Fam	929.01	19.61		Emp+Fam	740.54	19.61		Emp+Fam	852.17	19.61	
2EmpFam	536.79	19.61		2EmpFam	348.32	19.61		2EmpFam	459.95	19.61	

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	$ 8.55
□ 030038 Employee + 1	$16.47
□ 030039 Employee + 2 or more	$26.16

Blue Dental Choice PPO COINSURANCE Plan

□ 030024 Employee Only	$14.20
□ 030025 Employee + 1	$27.35
□ 030026 Employee + 2 or more	$43.45

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)

□ 020122 I have selected health insurance, thus my employer paid life option is $10,000 (*020125 reduced by 50% at 70 yoa)*

□ 020123 I have not selected health insurance, thus my employer paid life option is $30,000 (*020126 reduced by 50% at 70 yoa)*

□ 020124 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 reviewed information on the Benefits website & that you understand that you must contact the vendor representative to enroll in Reimbursement Accounts, Cancer Protection, Disability Income Protection etc.

Dependent Information - You must provide dependent verification when adding dependent(s)

A/D Add/ Delete	Name	Sex M/F	Social Security No.	Date of Birth	Relation to you	Physician Name HMO Only	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.**

NOTE: You must provide dependent verification documents when adding dependents to your plan. Overage dependents are not eligible for benefits. It is the member's responsibility to delete coverage for overage dependents, retroactive terminations are not allowed.