INSTRUCTIONS: BENEFITS ENROLLMENT FORM

This enrollment form is used to select your new or change your existing healthcare coverage at the County.

- **New Employees:** Please complete this form within 30 days of your date of hire. *Be sure to include applicable dependent documentation.*

- **Existing Employees:** All qualified life events must be submitted online via myOCportal within 60 days of the event. If unable to submit your Life Event request online, please be sure to reach out to Benefits@ocfl.net for assistance. *Paper enrollment forms will not be accepted without a prior authorization.*

- **Open Enrollment:** If you were on leave during the entire open enrollment period, please complete this form within 30 days of your return. *Be sure to include applicable dependent documentation.*

For additional information, refer to your Employee Benefits Handbook. If you have questions or need assistance, contact us at Benefits@ocfl.net or (407) 836-5661.

IMPORTANT INFORMATION – GLOSSARY TERMS:

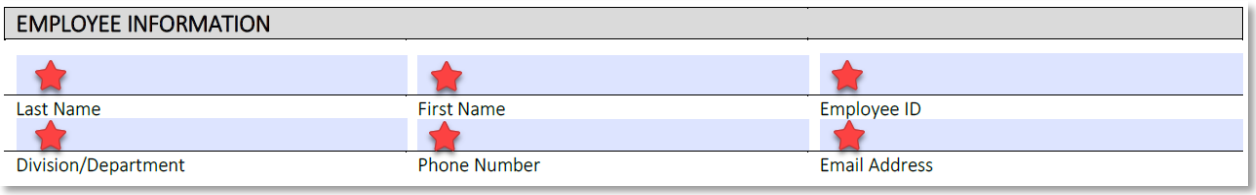
Action-No Change: Check this box if you would like Current coverage to remain as is
Action-Elect Coverage: Check this box to begin initial enrollment (no coverage currently exists)
Action-Waive Coverage: Check this box if you do not want coverage at all
Action-Add/Remove Dependents: Check this box if you have existing coverage but would like to add or remove covered dependents.
EE Only: Employee Only
EE + SP: Employee + Spouse
EE + CH: Employee + Child(ren)
EE + Family: Employee + Spouse + Children
EE + 1: Employee + 1 Dependent
EE + 2 or more: Employee + 2 or more Dependents
Dependent: Eligible family members as defined in your Employee Benefits Handbook.
HDHP: High Deductible Health Plan
LDHP: Low Deductible Health Plan
STD: Short Term Disability
FSA: Flexible Spending Account
HSA: Health Savings Account
Medical Underwriting: Evidence of insurability

HOW TO COMPLETE THE FORM:

Download/Save this form to your computer. Save as "EEID Name Benefits Enrollment Form".

In the **Employee Information** section, please enter the following:

- Last Name (as it appears on your Social Security card)
- First Name (as it appears on your Social Security card)
- Employee ID
- Division/Department
- Phone Number (personal)
- Email (personal)



Under **Enrollment Type**, complete the following:

- **Select One:** Check off New Hire, Open Enrollment, or Qualified Event. For qualified event, select applicable option from the drop-down menu. **Qualified events should be completed online; Paper enrollment forms will not be accepted without a prior authorization.*
- **Event Date:**
  - **New Employees:** Your date of hire.
  - **Existing Employees:** The date of your qualified event
  - **Open Enrollment:** Your return to work date.
- **Effective Date:** Leave this blank

ENROLLMENT TYPE *(select one)*:	☒ New Hire	☐ Open Enrollment	☒ Qualified Event	Select One (QE Only)
(Bi-Weekly rates listed in Benefits Handbook)		**EVENT DATE:** _____	**EFFECTIVE DATE:** Leave Blank	

Next, make your enrollment selections. Be sure to complete each section in its entirety and pay close attention to additional information provided in the various sections. Incorrect or incomplete forms will be sent back for corrections and may delay the effective date of your coverage.

Medical: (*Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect", "Waive", or "Add/Remove Dependents"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Dependent:** Select one. "EE only", "EE + SP", "EE + CH", or "EE + Family"
- **Plan Option:** Select one. "OrangePrime Plus (HDHP)", "OrangePrime (LDHP)", or "Tricare Supplement"

MEDICAL					
	Action	☐ **No Change**	☐ **Elect Coverage**	☐ **Waive Coverage**	☐ **Add/Remove Dependents**
	Dependent	☐ EE Only	☐ EE + SP	☐ EE + CH	☐ EE + Family
	Plan Option	☐ OrangePrime Plus (HDHP)		☐ OrangePrime (LDHP)	☐ TRICARE Supplement

Dental: (*Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect", "Waive", or "Add/Remove Dependents"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Dependent:** Select one. "EE only", "EE + 1", or "EE + 2 or more "
- **Plan Option:** Select one. "Low Plan", "Middle Plan", or "High Plan"

DENTAL					
	Action	☐ **No Change**	☐ **Elect Coverage**	☐ **Waive Coverage**	☐ **Add/Remove Dependents**
	Dependent	☐ EE Only	☐ EE + 1	☐ EE + 2 or more	
	Plan Option	☐ Low Plan	☐ Middle Plan	☐ High Plan	

Vision:

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect", "Waive", or "Add/Remove Dependents"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Dependent:** Select one. "EE only", "EE + 1", or "EE + 2 or more "

VISION					
	Action	☐ **No Change**	☐ **Elect Coverage**	☐ **Waive Coverage**	☐ **Add/Remove Dependents**
	Dependent	☐ EE Only	☐ EE + 1	☐ EE + 2 or more	

Additional Life: (*Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect Coverage", or "Waive Coverage"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Total Amount:** Enter total amount of coverage wanted. Use $0.00 if waiving coverage.
- **Medical Underwriting:** Check box if applicable.

ADDITIONAL LIFE				
Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	
Basic Life equal to your annual salary (county paid)	Total Amount $_____	*(increments of $10,000)*		Medical Underwriting Required *(see benefits handbook for rules)*
	** Supplemental life up to 5x your annual salary (Plan Max $300,000)*			

Spouse Life: (*Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect Coverage", or "Waive Coverage"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Total Amount:** Enter total amount. Use $0.00 if waiving coverage.
- **Medical Underwriting:** Check box if applicable.

SPOUSE LIFE				
Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	
Cannot exceed employee basic + additional life	Total Amount $_____	*(increments of $10,000)*		Medical Underwriting Required *(see benenfits handbook for rules)*
	** Plan Max $250,000*			

Child Life: (*Refer to your Employee Benefits Handbook for more information about this benefit)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect", "Waive", or "Add/Remove Dependents"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Total Amount:** Select $5,000 or $10,000. Leave this section blank if waiving coverage.

CHILD LIFE				
Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	☐ Add/Remove Dependents
Children can only be covered by one employee	Total Amount	☐ $5,000	☐ $10,000	

Short Term Disability: (*Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect Coverage", or "Waive Coverage"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Amount:** Select 15, 30, 60, 90, or 120 Day Wait period. Leave this section blank if waiving coverage.
- **Medical Underwriting:** Check box if applicable.

STD				
Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	Medical Underwriting Required *(see benefits handbook for rules)*
Amount	☐ 15-Day Wait	☐ 60-Day Wait	☐ 120-Day Wait	
	☐ 30-Day Wait	☐ 90-Day Wait		

Flexible Spending Account: (*Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect Coverage", or "Waive Coverage"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Deduction:** Enter deduction amount. Use $0.00 if waiving coverage
- **Plan Option:** Choose one. "Medical" or "Limited Purpose"

FSA				
	Action	☐ **No Change**	☐ **Elect Coverage**	☐ **Waive Coverage**
	Deduction	Deduct $ _____	per pay period ($15 minimum)	
	Plan Option	☐ Medical **available if HSA is not elected*		☐ Limited Purpose **Dental/Vision expenses only*

Dependent Care Flexible Spending Account: (*Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **Action:** Select one
  - **New Employees:** Choose "Elect" or "Waive" coverage.
  - **Existing Employees:** Choose "No Change", "Elect Coverage", or "Waive Coverage"
  - **Open Enrollment:** Choose "Elect" or "Waive" coverage.
- **Deduction:** Enter deduction amount. Use $0.00 if waiving coverage

DEP CARE				
	Action	☐ **No Change**	☐ **Elect Coverage**	☐ **Waive Coverage**
	Deduction	Deduct $ _____	per pay period ($15 minimum)	

Health Savings Account: (*Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- Select one
  - Check "HSA Election Form Attached" if you would like to have an HSA account.
  - Check "N/A" if you do not qualify for or do not want an HSA.

HSA		
	Only available if electing the OrangePrime Plus plan (HDHP)	☐ HSA Election Form Attached (required for HSA Participation) ☐ N/A I do not qualify for or do not want an HSA

Reminder: If you are selecting an HSA, you must also complete the HSA Election Form and open your account.

In the **Dependent Information** section, add all family members to be covered on Medical, Dental, Vision, and/or Life insurance.

Spouse: If you are adding your spouse to coverage you must complete this section. Leave it blank if not applicable.

- Check off "Spouse" and input "Marriage Date"
- Input "Last Name, First Name" (as listed on your spouse's social security card)
- Input "Date of Birth"
- Input "Social Security Number"
- Select appropriate "Gender"
- Check off "Spouse Life" if you selected "Spouse Life" insurance on page one. Leave it blank if not applicable
- Medical: Select one. "Elect" or "Waive"
- Dental: Select one. "Elect" or "Waive"
- Vision: Select one. "Elect" or "Waive"

Dependent information: List all family members to be covered and only select coverage type desired.
** Include copies of all required dependent documentation as outlined in your current benefits handbook*

Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
☐ Spouse *Marriage Date:*				☐ M ☐ F	☐ Spouse Life	☐ Elect ☐ Waive	☐ Elect ☐ Waive	☐ Elect ☐ Waive

Child/Grandchild: If adding your child/grandchild to coverage you must complete this section.

- Check off "Child" or "Grandchild"
- Input "Last Name, First Name" (as listed on your child/grandchild's social security card)
- Input "Date of Birth"
- Input "Social Security Number"
- Select appropriate "Gender"
- Check off all that apply: "Disabled", "Court Order", or "Child Life" Leave it blank if not applicable
- Medical: Select one. "Elect" or "Waive"
- Dental: Select one. "Elect" or "Waive"
- Vision: Select one. "Elect" or "Waive"

Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
☐ Child ☐ Grandchild ☐ _____				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive	☐ Elect ☐ Waive	☐ Elect ☐ Waive

Be sure to read your **Notice of Enrollment Rights** on page two. When you sign your election form, you are acknowledging and consenting to the information provided.

Sign & Date: Don't forget to electronically sign, add your employee ID number, and date the bottom of your enrollment form.

- Click review and sign link in email.
- Click prompt in document.
- Create signature.
- Select signature option.
- Sign document.
- Finalize signature
- Send

Please note, your requested plan change(s) will take 1-2 pay periods to be processed and become visible to you in applicable systems.

Employee Signature	EEID	Date

SUBMISSION PROCESS:

- Submit your completed form to the secure Box.com folder
- Refer to our Upload Documentation webpage for additional information

NEED HELP?

For additional information, refer to your Employee Benefits Handbook. If you have questions or need assistance, contact us at Benefits@ocfl.net or (407) 836-5661

Wellness For Life
Benefits Enrollment Form

EMPLOYEE INFORMATION

Last Name | First Name | Employee ID

Division/Department | Phone Number | Email Address

ENROLLMENT TYPE *(select one)*: ☐ New Hire ☐ Open Enrollment ☐ Qualified Event Select One (QE Only) Prior app

(Bi-Weekly rates listed in Benefits Handbook) EVENT DATE: _____ EFFECTIVE DATE: _____

MEDICAL	Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	☐ Add/Remove Dependents
	Dependent	☐ EE Only	☐ EE + SP	☐ EE + CH	☐ EE + Family
	Plan Option	☐ OrangePrime Plus (HDHP)		☐ OrangePrime (LDHP)	☐ TRICARE Supplement
DENTAL	Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	☐ Add/Remove Dependents
	Dependent	☐ EE Only	☐ EE + 1	☐ EE + 2 or more	
	Plan Option	☐ Low Plan	☐ Middle Plan	☐ High Plan	
VISION	Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage	☐ Add/Remove Dependents
	Dependent	☐ EE Only	☐ EE + 1	☐ EE + 2 or more	

ADDITIONAL LIFE	Action *Basic Life equal to your annual salary (county paid)*	☐ No Change Total Amount $_____ *(increments of $10,000)* ** Supplemental life up to 5x your annual salary (Plan Max $300,000)*	☐ Elect Coverage	☐ Waive Coverage	☐ Medical Underwriting Required *(see benefits handbook for rules)*
SPOUSE LIFE	Action *Cannot exceed employee basic + additional life*	☐ No Change Total Amount $_____ *(increments of $10,000)* ** Plan Max $250,000*	☐ Elect Coverage	☐ Waive Coverage	☐ Medical Underwriting Required *(see benefits handbook for rules)*
CHILD LIFE	Action *Children can only be covered by one employee*	☐ No Change Total Amount	☐ Elect Coverage ☐ $5,000	☐ Waive Coverage ☐ $10,000	☐ Add/Remove Dependents
STD	**Action** Amount	☐ No Change ☐ 15-Day Wait ☐ 30-Day Wait	☐ Elect Coverage ☐ 60-Day Wait ☐ 90-Day Wait	☐ Waive Coverage ☐ 120-Day Wait	☐ Medical Underwriting Required *(see benefits handbook for rules)*

FSA	Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage
	Deduction	Deduct $ _____ per pay period ($15 minimum)		
	Plan Option	☐ Medical **available if HSA is not elected*		☐ Limited Purpose **Dental/Vision expenses only*
DEP CARE	Action	☐ No Change	☐ Elect Coverage	☐ Waive Coverage
	Deduction	Deduct $ _____ per pay period ($15 minimum)		
HSA	*Only available if electing the OrangePrime Plus plan (HDHP)*	☐ HSA Election Form Attached (required for HSA Participation) ☐ N/A I do not qualify for or do not want an HSA		

B001 - Beneflex

Reset Form

Wellness For Life
Benefits Enrollment Form

Dependent information: List all family members to be covered and only select coverage type desired.
** Include copies of all required dependent documentation as outlined in your current benefits handbook*

Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
☐ Spouse *Marriage Date:* _____				☐ M ☐ F	☐ Spouse Life	☐ Elect ☐ Waive	☐ Elect ☐ Waive	☐ Elect ☐ Waive
☐ Child ☐ Grandchild ☐ _____				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive	☐ Elect ☐ Waive	☐ Elect ☐ Waive
☐ Child ☐ Grandchild ☐ _____				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive	☐ Elect ☐ Waive	☐ Elect ☐ Waive
☐ Child ☐ Grandchild ☐ _____				☐ M ☐ F	☐ Disabled ☐ Court Order ☐ Child Life	☐ Elect ☐ Waive	☐ Elect ☐ Waive	☐ Elect ☐ Waive

Notice of Enrollment Rights – *Please Read Carefully* – I understand that if I and/or my dependents, if any, waive coverage and desire to participate at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I Waive enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 60 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days after such event. Furthermore, employees are responsible for removing dependents from the plan within 60 days of the loss of eligibility event (i.e. divorce, dependent eligibility, etc). ***Any employee failing to provide the required information and documentation, or falsifying information and documentation, or listing ineligible individuals as eligible dependents, shall cause his or her dependents to be removed from the County's benefit plans. Additionally, that employee may be subject to disciplinary action up to and including termination of employment, may be required to reimburse the County for the benefits costs paid on behalf of the ineligible individual(s), and may be excluded from coverage all together under the County's benefits plans.***

The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my Wand/or my dependents' coverage and may subject me to disciplinary actions up to and including termination of employment. 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. I understand that coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. By signing this enrollment form, I hereby certify that all the information provided is true and correct.

Authorization to obtain or release medical information: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or confirmation pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original. I understand that some plans may contain a provision which excludes coverage for pre-existing conditions.

Authorization to provide identifying contact information: I authorize my employer to provide my identifying contact information (home address and telephone number) to any entity that manages, administers, evaluates or audits my employer's health care and benefits related programs, for the sole purpose of conducting those services, as applicable.

Payroll deduction authorization: I authorize my employer to reduce my salary in accordance with the benefits I have selected. I understand my selections cannot be changed unless I have a qualifying family status change as defined by the Federal Internal Revenue, Section 125 Code and request such changes within 60 calendar days of the qualifying event.

Please note, your requested plan change(s) will take 1-2 pay periods to be processed and become visible to you in applicable systems.

_____ _____ _____
Employee Signature EEID Date

Attention HR: Do not accept or sign until all required documentation is received.

_____ _____ _____
HR Representative Signature EEID Date

_____ _____ _____
HR Reviewer Signature (HR Analyst or above) EEID Date