JEFFERSON COUNTY COMMISSION
2024-2025 Benefits Change Form
DEADLINE TO ENROLL: 30 days from date of event

● **FOR ACTIVE EMPLOYEES ONLY**

Name (Please Print):		**Social Security Number (Last 4):**
Address:		**Home/Cell Phone:**
City:	**State:**	**Zip Code:**

Qualifying Life Event (QLE)	Required Documentation	Date of Qualifying Life Event
◯ Marriage or Divorce	State Issued Marriage License OR Final Divorce Decree	_____
◯ Birth or Adoption	State Issued Birth Certificate OR Adoption Decree	_____
◯ Guardianship	Court Ordered Guardianship Appointment	_____
◯ Spouse/Child Loss/Gain of employment	Proof of gain or loss of coverage; State issued Marriage License and/or Birth Certificate	_____
◯ Spouse/Child Loss/Gain of coverage	Proof of gain or loss of coverage; State issued Marriage License and/or Birth Certificate	_____
◯ Death of an eligible dependent	Death Certificate	_____
◯ Other_____		_____

BENEFIT PLANS – Please select all coverages you desire, even those in which you are currently enrolled.

MEDICAL – Blue Cross Blue Shield of AL	☐Terminate ☐Enroll ☐Dependent Change
☐ Single	$123.82
☐ Single + 1	$275.61
☐ Family	$358.06

DENTAL – Delta Dental	☐Terminate ☐Enroll ☐Dependent Change	
Please Select Plan (Check Box) →	**☐ Base**	**☐ Premium**
☐ Single	$23.16	$34.02
☐ Single + 1	$44.20	$64.92
☐ Family	$60.60	$89.01

VISION - EyeMed	☐Terminate ☐Enroll ☐Dependent Change	
Please Select Plan (Check Box) →	**☐ Base**	**☐ Premium**
☐ Single	$5.33	$7.84
☐ Single + 1	$10.65	$15.67
☐ Family	$15.62	$22.98

FLEXIBLE SPENDING -- Ameriflex	☐ Enroll ☐ Dependent Change ☐ Change contribution*
☐ Health Care	Amount: $_____ (Minimum $250 – Max $3,050/year)
☐ Dependent Care	Amount: $_____ (Maximum $5,000/year)

SUPPLEMENTAL LIFE – METLIFE	☐Terminate ☐Enroll ☐Dependent Change
☐ Employee *(Statement of Health may be required) **	Amount: $_____($5,000 increments 5x salary up to $750K)
☐ Spouse *(Statement of Health may be required) **	Amount: $_____ ($25,000 or $50,000)
☐ Child	Amount: $_____ ($5,000 or 10,000 per child)

SUPPLEMENTAL AD&D – METLIFE	☐Terminate ☐Enroll ☐Dependent Change
☐ Employee	Amount: $_____ ($5,000 increments, 5x salary up to $750K)
☐ Family	Amount: $_____ ($5,000 increments, 5x salary up to $750K)

MetLife Group Plans *(Premium Amounts listed below are Per Pay Period)*

Accident Insurance	☐Dependent Change
☐ Employee	$5.04
☐ Employee + Spouse	$9.01
☐ Employee + Child(ren)	$12.62
☐ Family	$16.59

Hospital Indemnity Insurance	☐Dependent Change
☐ Employee	$10.70
☐ Employee + Spouse	$20.44
☐ Employee + Child(ren)	$16.50
☐ Family	$26.25

Critical Illness Insurance	☐Dependent Change
☐ Employee	Cash Level: $_____ ($15,000 or $30,000)
☐ Spouse	Cash Level: $_____ (Max of 50% of employee coverage: $7,500 or $15,000)

List all dependents you want to add or remove from coverage. Write the letter "A" for ADD or the letter "R" for REMOVE in the box beside their name. Place an 'X' in the medical, vision and dental boxes to indicate coverage under the desired plan(s). Natural, step, foster, custodial and adopted children must be under age 26.

Add or Remove	Name	Relationship	Gender	Date of Birth	SSN	MEDICAL	VISION	DENTAL

Agreement/Signature - I hereby apply for the group benefit(s) listed above. My application is subject to the terms and conditions of the agreement between Jefferson County and the benefit carriers. I understand that my election cannot be changed during the year unless I experience a qualifying life event. I authorize Jefferson County to take deductions that may be required for the cost of these coverages. The information provided is true and correct to the best of my knowledge. Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, and or files a claim containing false or deceptive statement may be guilty of insurance fraud. **FORMS MUST BE SIGNED AND DATED. Forms not signed and dated and received by the 30th day after a qualifying life event will not be processed.**

I acknowledge by my signature that I have read and understand the above information.

Employee Signature: **Date:**

Mail the form to: Jefferson County Commission ▪ 716 Richard Arrington, Jr. Blvd. North Room A600, Birmingham, AL 35203 | ATTN: Human Resources – Benefits

Fax: (205) 325-5781

Scan and Email: benefits@jccal.org, ***be sure to send required documentation and dependent verification for newly added dependents.***

*** You will be contacted if a Statement of Health is required. See Enrollment Booklet for more details.**

* You can increase your current FSA contributions up to the applicable per-paycheck maximum. Or you can decrease current contributions to as little as $0/paycheck, subject to repayment of funds already disbursed from your account.

SEE PROVIDER BENEFIT SUMMARIES FOR ELIGIBILITY REQUIREMENTS

FOR INTERNAL USE ONLY	BENE	By	Date
	HRIS	By	Date

BENEFITS: DATE RECEIVED

2024-2025 JCC