

JEFFERSON COUNTY COMMISSION 2019-2020 Benefits Change Form DEADLINE TO ENROLL: 30 days from date of event

FOR ACTIVE EMPLOYEES ONLY

NAME – Please Print			Social Security Number:			
ADDRESS:		HOME/CELL PHO		NE:		
CITY: STA		ATE: ZIP CODE:				
Overlife in a Life French (OLF)		anninad Daam		Date of Overlifein at 15 Front		
Qualifying Life Event (QLE) Marriage or Divorce	equired Docur ed Marriage License	e/Final Divorce	Date of Qualifying Life Event			
	Decree	•				
Birth or Adoption		ed Birth Certificate/	•			
Guardianship		ered Guardianship A				
Spouse/Child Loss/Gain of employment	Marriage Li	iin/loss of coverage icense and/or Birth	Certificate			
Spouse/Child Loss/Gain of coverage		in/loss of coverage icense and/or Birth				
Death of an eligible dependent Death Cel		ificate				
Other						
BENEFIT PLANS - Please elect MEDICAL - Blue Cross Blue Shield		ages you desii □Termina				
☐ Employee				\$123.82		
☐ Employee + 1				\$275.61		
☐ Family				\$358.06		
DENTAL – Delta Dental		□Terminate	e	☐Dependent Change		
Please Select Plan (Check Box)		<mark>□ Ba</mark>	se	□ Premium		
☐ Employee		\$23.50		\$34.52		
☐ Employee + 1		\$44.86		\$65.89		
☐ Family		\$61.5	50	\$90.33		
VISION - EyeMed		□Terminat	te □Enrollment	☐ Dependent Change		
Please Select Plan (Check Box)		☐ Base		□ Premium		
☐ Employee		\$5.3	3	\$7.84		
☐ Employee + 1		\$10.6	65	\$15.67		
☐ Family		\$15.6	62	\$22.98		
FLEXIBLE SPENDING ACCOUNTS	- TASC	☐ Enrollm	ent Dependen	at Change		
☐ Health Care		Amount: \$		um \$300 – Max \$2,700/year)		
☐ Dependent Care		Amount: \$_	•	Maximum \$5,000/year)		
SUPPLEMENTAL LIFE – MET LIFE		□Termin	nate	nt □Dependent Change		
☐ Employee (Statement of Health may be required)		* Amount: \$		_(\$5,000 increments 5x salary up to \$750K)		
☐ Spouse (Statement of Health may be red		Amount: \$		(\$25,000 or \$50,000)		
☐ Child(ren)		Amount: \$_		_ (\$5,000 or 10,000 per child)		
CURRIEMENTAL ARON MET LIE	-	ПТ о изос ізо	oto □ □ □ □ □ □	nt Dependent Change		
SUPPLEMENTAL AD&D – MET LIF		☐Terminate ☐Enrollme Amount: \$		ent Dependent Change (\$5,000 increments, 5x salary up to \$750K)		
☐ Employee ☐ Family		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		65,000 increments, 5x salary up to \$750K)		
— ганшу		πησαπι. ψ	(1	50,000 indicinents, ox salary up to \$750K)		
Short Term Disability - METLIFE				of Health may be required) *		
☐ Employee		pre disability in 0 income)	come; Maximum we	ekly benefit \$1,730 (60% of Maximum		
Long Term Disability - METLIFE	□ Terminate □ Enrollment – (Statement of Health may be required) *					
☐ Employee	60% of pre disability income; Maximum monthly benefit \$7,500 (60% of Maximum \$150.000 income)					

Accides	nt Insurance	<mark>ım Amounts listed l</mark> □⊤.	erminate	□Enrol	Iment Descen	dent Change		
☐ Empl				<u>⊔Enroi</u> \$5.47	ппен пререпс	ieni onange		
	oyee + Spouse			\$9.79				
	oyee + Child(ren)			\$13.71				
☐ Fami	, ,			\$18.03				
<u> </u>	· <i>y</i>			+ 10.00				
Hospita	I Indemnity Insurance	□Term	inate	□Enrollme	nt □Dependent	Change		
☐ Empl	•		\$11.6		in Dependent	Change		
	oyee + Spouse		\$22.2					
	oyee + Child(ren)		\$17.9					
☐ Fami	` '		\$28.5					
Critical	Illness Insurance	□Те	rminate	□Enrollr	ment □Depende	ent Change		
☐ Empl	oyee	Cash Level: \$_		(\$10,0	00, \$20,000 or \$30,0	00)		
☐ Spou	se	Cash Level: \$_		(50% (of employee coverage	e; \$5,000, \$10	,000 or \$1	5,000
ロンハナナ	LEGAL	1						
HYATT ☐ Fami	ly Legal	\$18.00						
	ly Legal + ID	\$21.00						
				1				
Add or	Name	Relationship	Gender	Date of	SSN	MEDICAL	VISION	DENTA
	Name	Relationship	Gender	Date of Birth	SSN	MEDICAL	VISION	DENTA
or	Name	Relationship	Gender		SSN	MEDICAL	VISION	DENT
or	Name	Relationship	Gender		SSN	MEDICAL	VISION	DENT
or	Name	Relationship	Gender		SSN	MEDICAL	VISION	DENT.
or	Name	Relationship	Gender		SSN	MEDICAL	VISION	DENT
or	Name	Relationship	Gender		SSN	MEDICAL	VISION	DENT
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BENE Date FOR INTERNAL USE ONLY Ву HRIS Ву Date

BENEFITS: DATE RECEIVED

2019-2020 JCC