CDS FAMILY AND BEHAVIORAL HEALTH SERVICES
ANNUAL BENEFIT ENROLLMENT FORM
PLAN YEAR JULY 1, 2018 THROUGH JUNE 30, 2019

Please Complete the Following Information: (Please Print)

Employee Full Name (print): _____
Last First MI

SS#: _____-_____-_____ ☐ Male ☐ Female Date of Birth: _____-_____-_____
(Month) (Day) (Year)

Address: _____City _____ St _____ Zip_____

Email Address: _____ Job Title:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated Tobacco User: ☐ Yes ☐ No

Spouse Name: _____ SS#: _____-_____-_____ Date of Birth: _____-_____-_____
(Month) (Day) (Year)

If married, is your spouse covered by another health plan? ☐ Yes ☐ No

Child Name	Gender	Birth Date (mm/dd/yy)	Social Security #

BENEFICIARY: *Please designate a beneficiary for your Base Group Life Insurance.*

Primary: _____ *Relationship:* _____

Secondary: _____ *Relationship:* _____

EMPLOYEE AGREEMENT:

ASSOCIATE AGREEMENT: I hereby apply for the group benefits indicated by my elections on this enrollment form. I attest that the information I have provided on this form and on any additional forms my elections require is true to the best of my knowledge. I understand that this information will constitute the basis on which coverage will be issued or, if appropriate, denied.

I understand that coverage will not take effect unless I am actively at work and for my dependents will not take effect if they are confined to a hospital or other health care facility or are unable to perform the normal activities of someone of like age and sex, and that any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claims or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I attest that I understand the rules regarding pre-existing condition coverage limitations and evidence of insurability requirements for each coverage.

I further acknowledge that if coverage is provided to me or to any other person designated by me as an eligible dependent, I am guilty of fraud or intentional misrepresentation if (1) such person is ineligible for coverage per the terms of the Certificate of Insurance provided by the insurance carrier, or (2) such person ceases to be eligible per the terms of the Certificate of Insurance provided by the insurance carrier and I fail to promptly inform my employer or the insurance carrier. I acknowledge that the remedy for either of these actions on my part will be, among other things, immediate termination of the ineligible coverage.

In accordance with applicable Federal and State regulations, I authorize CDS to reduce my pay each pay period by the employee share of the cost for each coverage I have elected and to remit these reductions to the appropriate insurance carriers. I understand that my benefit elections cannot be changed prior to July 1, 2018 unless I have a change in my eligibility or a qualifying change in my family status.

Employee Signature: _____ Date: _____

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TO BE COMPLETED BY HUMAN RESOURCES

Position:_____ Date of Hire: _____ Rate of Pay: _____ Scheduled hours: _____

1. GROUP HEALTH INSURANCE (Florida Blue) refer to page 6-7 in Benefit Guide

☐ **I elect Health Insurance. (Choose type of coverage)**

☐ Silver Plan / Blue Care 53 (Copays apply on most coverages from start)

☐ Bronze Plan (HSA)/ Blue Care 128/129 (Copays apply after $2,500 deductible for Individual Coverage)

My coverage status is:

☐ Employee only ☐ Employee and Spouse

☐ Employee and Children ☐ Family (Employee, Spouse, & Children)

☐ **I do not elect Health Insurance**

Declining coverage due to existence of other overage:

☐ **Spouse Employer Plan** ☐ **Individual Plan**

☐ **Medicare** ☐ **Medicaid**

☐ **COBRA** ☐ **VA eligibility**

☐ **Tricare**

2. DENTAL INSURANCE (Guardian) refer to page 11-12 in Benefit Guide

☐ **I elect Dental Insurance. (Choose type of coverage)**

☐ Value Plan- at the in-network discounted reimbursement level

☐ Network Access (NAP) Plan (Based on Reasonable & Customary fee)

☐ **My coverage status is:**

☐ Employee only ☐ Employee and Spouse

☐ Employee and Children ☐ Family (Employee, Spouse, & Children)

☐ **I do not elect Dental Insurance**

3. VISION INSURANCE (Advantica) refer to page 14 in Benefit Guide

☐ **I elect Vision Insurance.**

☐ **My coverage status is:**

☐ Employee only ☐ Employee and Spouse

☐ Employee and Children ☐ Family (Employee, Spouse, & Children)

☐ **I do not elect Vision Insurance**

4. SUPPLEMENTAL GROUP LIFE INSURANCE (Reliance Standard): refer to page 17 in Benefit Guide

A. I DO NOT HAVE VOLUNTARY LIFE INSURANCE COVERAGE:

☐ I elect to ENROLL for Supplemental Group Life Insurance → Go to Section C & D → *Complete the Reliance Standard Application form.

☐ I do not elect Supplemental Group Life Insurance.

B. I AM CURRENTLY ENROLLED IN THE GROUP VOLUNTARY LIFE INSURANCE PLAN AND ELECT TO:

☐ MAKE NO CHANGES to my current Supplemental Group Life Insurance elections.

☐ MAKE CHANGES to my current plan (ADD, DECREASE OR DROP) → Go to Section C & D → *Complete the Reliance Standard Application form.

C. COVERAGE AMOUNTS FOR:

$	**MYSELF: Amount of Coverage on myself (multiple of $10,000 not to exceed $500,000)**
$	**SPOUSE: Amount of Coverage on my spouse (multiple of $10,000 not to exceed $500,000)**
$	**CHILDREN: Amount of coverage on my children ($2,500, $5,000, $7,500 or $10,000 for each child)**

*** Please complete the Reliance Standard application form for processing subject to underwriting approval.**

D. Beneficiary Designation: You must designate a beneficiary if you have elected this coverage. We ask you to complete this designation each year to ensure that the designation remains current. Remember that you may change your beneficiary at any time. Simply contact the Human Resource Coordinator.

If you elected coverage for your Spouse or Children, you are automatically the beneficiary for that coverage.

Primary beneficiary: _____ Relationship: _____

Secondary beneficiary: _____ Relationship: _____

5. SHORT TERM DISABILITY INSURANCE (Reliance Standard): refer to page 18 in Benefit Guide

☐ I elect Short Term Disability Insurance. (If you are not currently enrolled, please complete the Reliance Standard application form.)

☐ I do not elect Short Term Disability Insurance

6. LONG TERM DISABILITY INSURANCE (Reliance Standard) refer to page 18 in Benefit Guide

☐ I elect Long Term Disability Insurance. (If you are not currently enrolled, please complete the Reliance Standard application form.)

☐ I do not elect Long Term Disability Insurance

7. FLEXIBLE SPENDING ACCOUNTS (FSA): refer to page 20 in Benefit Guide

A. DEPENDENT CARE ACCOUNT

☐ I elect to redirect a part of my compensation to a Dependent Care Account in order to pay dependent care costs on a pre-tax basis. The amount to be deposited each pay period is: $ _____

☐ I do not elect the Dependent Care Account

B. MEDICAL CARE ACCOUNT

☐ I elect to redirect a part of my compensation to a Medical Care Account in order to pay qualifying expenses on a pre-tax basis. The amount to be deposited each pay period is: $ _____

☐ I do not elect the Medical Care Account

8. PRE-PAID LEGAL PLAN/IDENTITY THEFT SHIELD: refer to page 22 in Benefit Guide

☐ I elect to participate in the Pre-Paid Legal Plan only

☐ I elect to participate in the ID Theft Shield Plan only

☐ I elect to participate in the combined Pre-Paid Legal/ID Theft Shield Plan

☐ I do not elect to participate in either plan

❖ **To enroll, you must complete a separate application**

9. SICK LEAVE POOL

☐ I elect to join the Sick Leave Pool. Please allocate _____hours to the Pool for the next plan year (minimum 2 hours, maximum 40 hours).

10. SUPPLEMENTAL COVERAGES (refer to page 21 in Benefit Guide)

Colonial Election

☐ **I do not have Colonial supplemental coverage(s) and am interested in enrolling for the following:**

☐ Accident ☐ Medical Bridge

☐ Cancer ☐ Critical Illness

***Costs of coverage varies. Please complete the Colonial Life application form.**

☐ **I currently have supplemental coverage with Colonial and wish to continue paying for this coverage via payroll deduction for the next plan year.**

☐ **I currently have supplemental coverage with Colonial and wish to cancel this coverage. Please discontinue deducting this cost from my pay → Complete box below.**

CANCEL: **(Please specify coverage(s) to cancel)**	

If you are interested in receiving more information about coverages currently available, please contact Ken McDougall at 1-888-899-4135.