

PINAL COUNTY 2008 ENROLLMENT FORM



(Return to Pinal County Human Resources upon completion)

NAME OF APPLICANT FIRST:		MI:	LAST:
MAILING ADDRESS:	STREET	CITY	STATE ZIP
HOME PHONE NUMBER:	WORK PHONE NUMBER:	SOCIAL SECURITY NO:	EMPLOYEE ID NUMBER:
SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	DATE OF BIRTH / /	MARITAL STATUS:	DATE OF HIRE:

ENROLLMENT INFORMATION

(Please place a check mark by the coverage you are electing. All rates specified are annual amounts)

MEDICAL: Employee Only Employee & Spouse Employee & Children Employee & Family (including Spouse)

I elect to waive Medical Coverage. (You must list Group Medical Coverage Below)

Plan/Carrier Name: _____ Group Number: _____ Medical

Policy Holder Name: _____ ID# _____

DENTAL: Basic Dental Plan Employee Only Employee plus one or more dependents

Extended Dental Plan Employee Only Employee plus one or more dependents

VISION: Employee Only Employee plus one or more dependents

MUST LIST SPOUSE AND ALL DEPENDENTS TO BE COVERED

First Name	MI	Last Name	Relationship	Gender	Date of Birth	Live Out of State? (Y/N)

BASIC LIFE INSURANCE: Basic Life, AD&D, & Dependent Life

(All full-time employees are required to have this coverage. **The cost is covered by the County Benefit Contribution**)

Beneficiary Information:

X _____
 (First) (Last) (Mailing Address) (City, State, Zip) (Relationship)

SUPPLEMENTAL LIFE INSURANCE: Employee up to \$350,000 in \$5,000 increments. Spouse: \$5,000 Children(each): \$1,000
 (Purchased with County Contribution or after-tax dollars)

Employee Only Employee & Family Enter Supplemental Life Amount Chosen: \$ _____

SHORT TERM DISABILITY: (Purchased with County Contribution or after-tax dollars)

Employee Only Cost of Benefit: \$ _____

FLEXIBLE SPENDING ACCOUNTS: (You may only use \$2,650 of the County Contribution toward this benefit.)

I want to elect a HEALTH CARE Flexible Spending Account. (Maximum Amount: \$2,650) Election Amount: \$ _____

I want to elect a DEPENDENT CARE Flexible Spending Account. (Maximum amount: \$5,000) Election Amount: \$ _____

COORDINATION OF BENEFITS

Is your spouse employed? Yes No N/A Spouse's Employer: _____

Are you, your spouse or dependents covered under another group plan or Medicare: Yes No

Plan/Carrier name: _____ Insured's Name: _____

EMPLOYEE ASSISTANCE PROGRAM (Pinal County pays for this benefit)

I have received and read the materials explaining the Pinal County Benefits Plan. I understand that by signing and submitting this form, I am making benefit elections for the above Plan Year. My election will remain in effect from the effective date of my coverage to the end of the Plan Year, subject to allowed family status changes according to the Pinal County Plan Document, and subject to any changes Pinal County deems necessary. I certify that the information I have provided is correct to the best of my knowledge. I authorize Pinal County to deduct from my salary the amount I must contribute to pay for the chosen benefits.

EMPLOYEE SIGNATURE: _____ DATE: _____