



Pinal County FY 2016-2017 Enrollment / Change Form

(Return to Pinal County Human Resources Upon Completion)



PART I Employee Information

<input type="checkbox"/> Change Employee Last Name		First Name		Middle Initial
<input type="checkbox"/> Change Mailing Address		Social Security #		Employee ID#
City		State	Zip Code	Date of Hire (Month/Day/Year)
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (Month/Day/Year)	Home Phone #	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D	Part-Time employee that works 30 hours or more? <input type="checkbox"/> Yes
		Work Phone #		

PART II Reason for Enrollment

New Hire Open Enrollment Qualifying Life Event (Marriage, Birth/Adoption, Divorce, Termination, Death, Dependent Age Limit, Loss of Coverage, etc.)

Date of Qualifying Event: _____

Waive

I elect to waive Medical Coverage (If you waive coverage, you must list your Group Medical Coverage below)

Plan/Carrier Name: _____ Policy Holder Name: _____ Group #: _____ ID#: _____

PART III Benefit Selection

MEDICAL: EPO PPO (BU) HDHP/HSA**

Employee Only Employee+ Spouse Employee + Child(ren) Employee + Family (including spouse)

DENTAL: Employee Only Employee+ Spouse Employee + Child(ren) Employee + Family (including spouse) Waive Dental

VISION: Employee Only Employee+ Spouse Employee + Child(ren) Employee + Family (including spouse) Waive Vision

***For HDHP Plan Only:
 ***HSA ANNUAL ADDITIONAL CONTRIBUTION: Amount: \$ _____

HSA annual max combined contribution: \$3,350 Individual, \$6,750 Family, \$1,000 Catch-up contribution for age 55+.

FLEXIBLE SPENDING ACCOUNT (FSA)

Health Amount: \$ _____ (maximum amount: \$2,550) Limited Purpose FSA***

Dependent Care Amount: \$ _____ (maximum amount: \$5,000/\$2,500 if married filing separately)

SUPPLEMENTAL LIFE INSURANCE: EMPLOYEE Yes No Amount: \$ _____ (max amount is lesser of \$500,000 or six (6) times annual salary)
(Pinal County provides \$50,000 of Basic Life and AD&D at no cost to the employee. Employees may choose to elect additional Supplemental Life Insurance in increments of \$10,000 up to max of \$500,000 or 6x annual salary, whichever is less.)

SPOUSE Amount: \$ _____ (max is \$250,000, in increments of \$5,000 not to exceed Employee amount)

CHILD(REN) Amount \$2,500 \$5,000 \$7,500 \$10,000

SUPPLEMENTAL AD&D: EMPLOYEE Yes No Amount: \$ _____ (Increments of \$10,000 not to exceed \$500,000)

SPOUSE Amount: \$ _____ (Up to 50% of Employee AD&D or 40% with Child(ren))

CHILD(REN) Amount: \$ _____ (Up to 15% of Employee AD&D or 10% with Spouse)

PART IV Covered Dependent Information

	First and Last Name	MI	Gender	DOB Eligible dependent children must be less than age 26	SS#	Indicate A = Add D = Drop	Type of Coverage:			
							Medical	Dental	Vision	Life
Spouse										
Child										
Child										
Child										
Child										
Child										

PART V Coordination of Benefits

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

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

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 Qualified Life Event 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 all eligible premiums on a pretax basis unless I elect my premiums to be deducted on post-tax basis. (post-tax forms available in HR Office).

EMPLOYEE SIGNATURE _____ **DATE:** _____

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INSTRUCTIONS

Plan Year: July 1, 2016 – June 30, 2017

Eligibility:

1. Employees are eligible to sign up for benefits upon hire. Benefits are effective the first of the month following 30 days from hire date. For employees hired in February, benefits start on April 1st.

Deadline for enrollment or change submissions:

1. **Open Enrollment:** Enrollment paperwork must be submitted by 5:00pm May 20, 2016. If paperwork is not received prior to this deadline, you will be "auto-enrolled" in the Employee Only PPO Medical plan, Basic Life Insurance, and Short-Term Disability.
2. **New Hire:** Enrollment paperwork must be submitted within 31 days of your hire date. If paperwork is not received prior to this deadline, you will be "auto-enrolled" in the Employee Only PPO Medical plan, Basic Life Insurance, and Short-Term Disability. This enrollment will be in effect until the sooner of 1) the next Open Enrollment, or 2) you experience a Qualifying Life Event.
3. **Qualifying Life Event:** Enrollment /Change Forms due to a Qualifying Life Event **must** be submitted within 31 days of the Event.

PART I Employee Information

Complete requested information.

PART II Reason for Enrollment

1. **Changes to enrollment:** may only be made at time of New Hire and/or Open Enrollment, with the exception of changes due to a Qualifying Life Event. Qualifying Life Events include:
 - a. Change in legal marital status: Marriage, divorce, legal separation, annulment, death of spouse;
 - b. Change in the number of dependents: Birth, adoption, or death of dependent child;
 - c. Change in employment status or work schedule: Start or termination of employment or change in employment status of the employee, their spouse or their dependent child;
 - d. Change in dependent status under the terms of this Plan. Age or any other reason provided under the definition of an eligible dependent;
 - e. Change of residence or worksite: If the change impairs the Plan Member's ability to access the services of in-network providers;
 - f. Change required under the terms of a Qualified Medical Child Support Order (QMCSO);
 - g. Eligibility for or cancellation of coverage under Medicare, Medicaid or the Children's Health Insurance Program (CHIP);
 - h. Increase to the Employee in the cost of the benefits;
 - i. Significant changes in the benefits;
 - j. Changes in spouse's, former spouse's or dependent's coverage through their employer.

PART III Benefit Selection

1. **Medical Plan:** Select your plan by checking the box next to the desired plan.
 - a. Select the type of coverage based on who you will be covering on your medical plan. Check the box next to the desired level of coverage. If you waive medical coverage, check the "waive medical" box and also complete the waive information in Section II.
2. **Dental & Vision:** Select the level of coverage. If you do not want Dental or Vision coverage, check the Waive Dental or Waive Vision box.
3. **HSA:** Enter the additional annual contribution amount you would like to make into your HSA.
4. **Flexible Spending Account (FSA):** The maximum an employee can allocate of County contribution dollars is \$2,550 to the Health FSA. Not all Qualifying Life Events allow for changes to FSA.
 - a. **Health FSA:** Maximum amount is \$2,550.
 1. Payment/Reimbursement method will be a debit card referred to as the **Benny Card** or via claim submission & direct deposit.
 - b. **Dependent Care FSA:** Maximum amount is \$5,000 or \$2,500 if married filing separately.
5. **Employee Supplemental Life Insurance:**
 - a. \$150,000 "Guaranteed Issuance" is available at time of new hire only. \$10,000 "Guaranteed Issuance" for existing employees.
 - b. An Evidence of Insurability (EOI) Form must be completed:
 - At time of new hire only if requesting any amount in excess of \$150,000.
 - To request an increase greater than \$10,000 to an employee's current level of life insurance.
 - For new enrollment for existing employees requesting more than \$10,000.
 - c. Amount requested must be in increments of \$10,000.
 - d. Maximum selection amount is the lesser of \$500,000 six (6) times your annual salary.
 - e. Supplemental Life Insurance is optional, and additional to the \$50,000 Basic Life Insurance that the County provides.
 - f. Supplemental Life Insurance may be increased annually by \$10,000 until the guaranteed issue maximum of \$150,000 without an EOI.
6. **Dependent Supplemental Life Insurance:** Spouse: Increments of \$5,000 up to max of \$250,000; cannot exceed Employee combined Basic & Supplemental Life amount. Child(ren): Select amount by checking the box next to desired amount.
7. **Supplemental AD&D: Employee:** Increments of \$10,000 up to max of \$500,000 **Spouse Only:** Up to 50% of employee supplemental AD&D. **Child(ren) Only:** Up to 15% of employee supplemental AD&D. **Spouse & Child(ren):** Up to 40% of employee supplemental AD&D for Spouse and up to 10% of employee supplemental AD&D for child.

PART IV Covered Dependent Information

1. Eligible Dependents are defined as:
 - a. Legal spouse.
Dependent children under age 26, regardless of F/T student status for medical, age 19 for dental and vision (age 24 if full-time student). Includes natural living children, adopted children or children placed with you in anticipation of adoption, foster children, and step children.
 - b. Disabled dependents (requires medical proof), and Qualified Medical Child support Orders (requires proof or court ordered support).
2. If covering dependents, you **must** provide a completed Dependent Eligibility Form as well as acceptable documentation validating dependent eligibility. A list of acceptable documentation can be found on the reverse side of the Dependent Eligibility Form.
3. A Social Security number is required for each covered dependent.

PART V Coordination of Benefits

1. If your legal spouse is employed, please provide the employer's name.
2. If you and/or your spouse are covered under another carrier's plan, please provide the Plan/Carrier name.

(Please refer to the Plan Document and Summary Plan Description for further details.)