Lee County Human Resources

Add or Delete Spouse/Dependent

Legible copies of these documents must be provided in order for dependents to be added to the insurance plans.

Adding Spouse or Dependent(s)

Spouse

Copies of:

- Birth certificate or driver's license or US passport
- Social security card
- Marriage license
- COBRA Acknowledgement Form - Spouse

Dependents

Copies of:

- Birth certificate
- Social security card
- Legal Documentation for adoption, fostering, or court appointed guardianship
- Step-children- marriage certificate, birth certificate & social security card

Dropping Spouse

- Copy of first and last page of final divorce decree, must be included to remove spouse.
- Letter stating gain or loss of coverage – start and end dates.

BENEFITS ENROLLMENT AND CHANGE FORM

Lee County Human Resources

☐ NEW HIRE ☐ PT to FT Effective Date _____

☐ CHANGE Reason: _____

EMPLOYEE INFORMATION

First Name	MI	Last Name	SSN	Date of Hire
Street Address			City/State/Zip	Date of Birth
Entity	Department	Division	Work Phone	Home Phone

MEDICAL, DENTAL, VISION ELECTIONS

	Aetna Select	Aetna POS II	Dental	Vision Basic	Vision High
Employee Only	☐ $ 15.00	☐ $ 15.00	☐ $ 5.00	☐ $ 8.45	☐ $14.70
Employee & Family	☐ $160.00	☐ $160.00	☐ $40.00	☐ $ 16.45	☐ $ 28.07
Employee & Spouse	☐ $145.00	☐ $145.00			
Employee & Children	☐ $115.00	☐ $115.00			
Decline	☐	☐	☐	☐	☐

FAMILY INFORMATION

(Below place an "A" to Add "R" to Remove)

Last Name, First Name, MI	SSN	Date Of Birth	Relationship (S)pouse (D)ependent (G)randchild	Sex M F	Medical A R	Dental A R	Vision Basic A R	Vision High A R
Spouse								
Dependent(s) / Grandchild								

SIGNATURE PRINTED NAME DATE

PRETAX PREMIUM PLAN: Medical, dental, vision, and flexible spending account contributions will not be subject to Federal Income or Social Security taxes and changes to your coverage can only be made as a result of an approved qualifying change in family status.

NOTE: IMPORTANT INFORMATION PLEASE READ AND REVIEW. YOU ARE AUTHORIZING A RELEASE OF YOUR MEDICAL INFORMATION.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security Number for purpose of identification.

The Standard Insurance Company

Lee County Board of County Commissioners
Beneficiary Designation Form

I Am Completing This Form for ☐ Basic Life/ADD ☐ Optional Life ☐ Both

Employee Name *(Last, First, Middle)*	**Social Security Number**
Address *(Street, City, State, Zip Code)*	**Phone Number**

- This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance and Life with Accidental Death & Dismemberment (AD&D) Insurance.
- Designations made below, or on a separate sheet of paper, are not valid unless singed, dated, and delivered to your Employer during your lifetime.
- Return the completed form to your Human Resources Department.

Primary Beneficiary (the total of all primary beneficiaries must equal 100%)

	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
1.					
	Address			Phone Number	
2.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	Address			Phone Number	
3.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	Address			Phone Number	

TOTAL
The total share of all primary beneficiaries must equal 100%.

Contingent Beneficiary (the total of all contingent beneficiaries must equal 100%)

	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
1.					
	Address			Phone Number	
2.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	Address			Phone Number	
3.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	Address			Phone Number	
4.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
	Address			Phone Number	

TOTAL
The total share of all contingent beneficiaries must equal 100%.

Employee Signature:	Date:

Complete form and retain a copy for your records.

The Standard Insurance Company

Remember the following when completing your Beneficiary Designation form:

- Your destination revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example," Dorothy Q. Smith, Trustee under the trust agreement dated_____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefits" box (es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary – John Q. Doe, 60%; Jane Q. Doe, 40%.

To assist you, here are some examples of clear beneficiary designations.

One Primary and two Contingent Beneficiaries	One Primary and three Contingent Beneficiaries
Primary Beneficiary: Jane Smith, Spouse, 100%, **Contingent Beneficiaries:** Paul Jones, Brother, 50% Mary Park, Sister, 50%	**Primary Beneficiary:** Gayle Rich, Spouse, 100% **Contingent Beneficiaries:** Teresa Rich, Daughter, 40% Susan Rich, Daughter, 40% Jason Rich, Brother, 20%

Complete form and retain a copy for your records. Please return the completed form to Lee County Human Resources.

The Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

Lee County Human Resources

Standard Insurance Company
Optional Life Enrollment and Change Form

Group Number	Division	Date of Hire	Benefit Effective Date
164657			

To Be Completed By Employee

Employee Name (Last, First, Middle)	Social Security Number	Birth Date	Male ☐ Female ☐	
Address		City	State	ZIP
Former Name (Last, First, Middle) *Complete only if name change*			Phone Number	
Employer Name **Lee County Board of County Commissioners**			Job Title/Occupation	
Hours Worked Per Week _____				

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

Additional Life requested amount $_____

Spouse Life Insurance

Spouse Life requested amount $_____

Spouse Name_____ Spouse Date of Birth _____

Dependent Life Insurance

Life requested amount $_____

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form to your Human Resources Department.

Lee County Human Resources

FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

*To enroll, complete the following information, sign the form, and return it to **Human Resources**. To avoid processing delays, please complete all fields on the application and print clearly.*

Department: _____

Employee Name:_____ **SSN:** XXX-XX-_____

Employee Address/City/State/Zip code:_____ **Phone Number:** _____

EMPLOYEE'S FLEXIBLE SPENDING ACCOUNT ELECTION

Enrollment Reason (please check one): ☐ **New Hire** ☐ **Open Enrollment** ☐ **Other:** _____

FSA Election Effective Date: _____ **Payroll Frequency : *Bi-Weekly**

***Annual Elected FSA Amounts are deducted from two pay periods each month, which will consist of 24 deductions per year.**

☐ I hereby elect NOT to participate in the Flexible Spending Accounts
☐ I hereby elect to participate in the following Flexible Spending Accounts:

Benefit	Per Pay Period *$25 minimum*	# Pay Periods *24 annually, or number of pay periods remaining in the calendar year*	Annual Election Amount
☐ **Healthcare FSA** *(medical, dental, vision expenses not covered by any plan)* **$3,200 annual maximum**	**$**		**$**
☐ **Dependent Care FSA** (*out-of-pocket **day care expenses** children under age 13 or elder tax dependent for whom you are responsible)* **$5,000 annual maximum**	**$**		**$**

I understand the choices I have indicated above are IRREVOCABLE unless a "qualifying status change" occurs as defined by the Internal Revenue Service. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Service Code Section 125 if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for expenses are not filed within the required time-period. I understand if I am terminated, discharged, or have my hours reduced to less than 30 hours per week, I will be automatically terminated from the plan. If termination from the plan occurs either voluntarily or involuntarily, or if I stop all contributions, no *benefits will be paid for any expenses incurred for dependent care and/or medical services after the termination date, and any plan contributions made after the termination date will be refunded, subject to taxation.*

I hereby authorize Lee County to adjust my salary in accordance with the above elections. I have read and fully understand the rules governing this plan. If for any reason the information provided above should change, I will immediately notify my employer. I understand that falsification of any information on this application or my reimbursement forms may result in termination of my employment and will require full reimbursement by me of all benefits paid under this plan.

Employee Signature **Date**

1825 Hendry Street - Suite 200
Fort Myers, FL 33901
Phone (239)533-2245. Fax (239)533-2052. benefits@leegov.com

COBRA ACKNOWLEDGEMENT FORM FOR SPOUSE

Your spouse was given a copy of an initial COBRA notice upon commencement of employment, with instructions to deliver a copy to you. This certifies that you have received a copy of your rights pertaining to limited continuation of coverage for health benefits for you and your covered dependents under the Public Health Services Act.

_____ _____

(Print EMPLOYEE'S name) (Print EMPLOYEE'S SSN)

_____

(Print SPOUSE'S name)

Governmental Entity: (check one or indicate other)

☐ BOCC ☐ Lee County Clerk of Courts ☐ Court Administration
☐ Port Authority ☐ Tax Collector ☐ Property Appraiser
☐ Elections ☐ Other _____

_____ _____

Spouse's Signature Date

Please return this completed form to:
Lee County Human Resources
Attn: Benefits
P.O. Box 398
Fort Myers, Florida 33902