

Clermont County 2009 New Hire Benefit Election/Change Form

New Hire: Full time date of hire _____

Part-Time to Full-time: Original date of hire _____ Full-Time date _____

Change (documentation required): Qualifying event _____ Qualifying Event Date _____

EMPLOYEE INFORMATION											
Clock #:	Dept #:	Dept Name:	Work Phone:	Home Phone:						If married, is spouse a Clermont County employee? <input type="checkbox"/> Y <input type="checkbox"/> N	
Last Name:		First Name:		SS#:		Date of Birth:					<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			Apt:	City:		State:	Zip:		<input type="checkbox"/> Single <input type="checkbox"/> Married		

ELECTION INFORMATION (deductions are 2x per month)					
Health Care Plan Choices / Deductions	Voluntary Life Insurance <i>Attach completed life enrollment form</i>	Flexible Spending Account (FSA) <i>Attach completed Chard-Snyder Form</i>	Health Plan Deduction Totals: <i>(Enter per pay totals below)</i>		
Medical: (choose one) NPOS1: <input type="checkbox"/> Single \$9.22 <input type="checkbox"/> Family \$126.96 NPOS2: <input type="checkbox"/> Single -\$6.58 <input type="checkbox"/> Family \$82.71 WAIVE <input type="checkbox"/> Credit -\$30.00	Dental: <input type="checkbox"/> Single \$12.95 <input type="checkbox"/> Family \$35.61 <input type="checkbox"/> Waive	Vision: <input type="checkbox"/> Single \$3.36 <input type="checkbox"/> Family \$8.48 <input type="checkbox"/> Waive	Amount of Coverage: Per Pay: Employee: \$ _____ \$ _____ Spouse: \$ _____ \$ _____ Child(ren): \$ _____ \$ _____ <i>(See back of form for enrollment information)</i>	HealthCare: Annual Election: Per Pay*: \$ _____ \$ _____ Dependent Day Care: Annual Election: Per Pay*: \$ _____ \$ _____ <i>*Divide your annual election by the number of months left in the year, then divide by 2 to get your per pay deduction.</i>	Medical: \$ _____ Dental: \$ _____ Vision: \$ _____ Emp. Vol. Life: \$ _____ Spouse Life: \$ _____ Child Life: \$ _____ FSA Health: \$ _____ FSA Daycare: \$ _____
TOTAL:					

ELIGIBLE DEPENDENTS										
Dependent Name (First, Last)	Spouse / Child	Male / Female	Date Of Birth	Social Security #	Medical <small>Add/Del</small>	Dental <small>Add/Del</small>	Vision <small>Add/Del</small>	Disabled	FT Student age 19-25	Other Coverage? Type? <small>Please attach plan information</small>
	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

EMPLOYEE: I certify that the information provided on this form is true & accurate. I understand that my elections will remain in effect through December 31st of each year & acknowledge that I cannot make any changes to my elections during the plan year unless I experience a qualifying event. I authorize Clermont County to take the corresponding payroll deductions for the benefits I have elected.

Employee Signature: _____ Date: _____

PAYROLL DEPT:	Single Plan	Family Plan
County Contribution:	\$175.33	\$380.88
NPOS 1 Emp. Ded:	\$9.22	\$126.96
NPOS 1 Actual Cost:	\$184.55	\$507.84
County Contribution:	\$175.33	\$380.88
NPOS 2 Emp. Ded: (credit) -\$6.58	\$82.71	
NPOS 2 Actual Cost:	\$168.75	\$463.59

HR USE ONLY

Effective Date: _____

NEW HIRE ENROLLMENT INFORMATION:

- In general, benefits become effective the 1st day of the month following 90 days of full time employment.
- Your legally married spouse may be covered if you elect a family plan - you must include them in the dependent section.
- Dependent children can be covered up to age 19, or age 25 if still a dependent & a full time student at an accredited school. A child who becomes disabled (as determined by social security) while still a 'dependent' may also be considered an eligible dependent regardless of age.
- Once elected, coverage will be in effect for the remainder of the current plan year, only a 'qualifying event' will allow you to change coverage.
- To ensure your coverage is in effect on the date you become eligible, please complete the enrollment form & give to your healthcare coordinator ASAP, prior to your eligibility date.

CHANGE ENROLLMENT INFORMATION:

- **Medical & flexible spending accounts can only be changed due to a 'qualifying event' such as divorce, marriage, birth, adoption, loss of other coverage, change of dependent status, etc.** The completed change form along with supporting documentation must be submitted to Human Resources within 30 days of the 'qualifying event'.
- Voluntary life can be reduced or dropped at anytime. Increases in the level of coverage & new coverage can only be applied for during 'open enrollment'. Coverage for a new spouse or new dependent child can be added within 30 days of the date the spouse or child became your dependent, provided you already have coverage for yourself. Beneficiary information can be updated at anytime.

BENEFIT INFORMATION:

- MEDICAL:** Carrier: Humana; Group #594390; web site: www.humana.com; Enrollment: Select one plan/coverage option.
- DENTAL:** Carrier: DentalCare Plus; Group # 1084; web site: www.dentalcareplus.com; Enrollment: Select single, family or waive.
- VISION:** Carrier: EyeMed; Group #9684499; web site: www.eyemedvisioncare.com; Enrollment: Select single, family or waive.
- VOLUNTARY LIFE:** The County provides you with \$25,000 in basic life & accidental death & dismemberment coverage at no cost to you. You can also elect additional coverage through the voluntary life, employee paid, plan:
 - Employee coverage can be purchased up to the 'guaranteed issue amount' of \$110,000 or 5x your annual salary (whichever is lower) & up to \$50,000 for your spouse, without having to submit any medical information. The child life maximum is \$20,000.
 - You must have coverage on yourself to be able to elect coverage for your spouse and/or dependent children.
 - Coverage for your spouse can be equal to but not greater than the coverage you elected for yourself.
 - Coverage for dependent children cannot be greater than 50% of the coverage you elected for yourself.
 - You can apply for employee coverage of up to \$250,000 (but no more than 5x annual salary) and/or spousal coverage up to \$100,000, but you must submit an evidence of insurability (EOI) declaration to CIGNA with your application. Coverage amounts over the 'guaranteed issue' will begin when & if CIGNA approves your application.
 - Employee & Spouse coverage is age rated so your actual cost will depend on how much insurance you elect & your age. Child life is one premium amount no matter how many children are eligible for coverage.
 - Complete the county's life/beneficiary form – even if you are not electing voluntary life. Transfer voluntary life information (if electing) to the space provided on the 'election' form.
- FLEXIBLE SPENDING ACCOUNTS (FSA):** Carrier: Chard-Snyder; web site: www.chard-snyder.com; phone # 513-459-9997
 - Healthcare FSA is a method for you to save some of your paycheck, on a pre-tax basis, in an account to be used for healthcare expenses not covered by insurance plans – you do not have to be a participant in any county benefit plan to be able to enroll in this plan. You may elect to put up to a combined total of \$5,000 annually per household into a healthcare FSA.
 - Dependent Daycare FSA is similar to the healthcare account but is used to pay daycare expenses for your qualified children under the age of 13 and/or a disabled parent. Only expenses that are incurred while you & your spouse are at work or actively looking for work, or while in class as a full time student qualify for as claims under this account.
 - The County will provide you with a 'debit card' at the County's expense, which will allow you easy access to your funds.
 - Complete the CHARD-SNYDER election form. Transfer the annual election amount to the space provided on your 'Enrollment / Change' form.
 - Divide your annual amount by the number of months left in the year & then divide that number by 2. This will be your per pay deduction.
- COMPLETION OF THE ENROLLMENT / CHANGE FORM:** Enter all the deductions for the benefits you have elected in the column provided to the right of the election section. Total & enter in the 'per pay total'. This will be your payroll deduction.

Next: Complete the dependent information – include all dependents you wish to cover on your plan (your spouse is considered a dependent too, so please don't forget to include him/her if you are electing family coverage!!). Sign, date & make a copy for your records.

Finally: Attach your Chard-Snyder form, Life Insurance beneficiary / election form & HIPAA release form. Give to your healthcare coordinator.

General information concerning the cost-sharing for the County's medical plan

Note: 'per pay' indicates twice per month. There are usually 2 months per year that have 3 pay, the last of which does not have benefit deductions taken.

For healthcare in 2009 the County will contribute \$175.33 per pay toward the cost of an employee only plan & \$380.88 toward the cost of a family plan. In addition, the County will offer a credit of \$30.00 per pay to those employees who 'waive' medical coverage. FYI, following is the per pay breakdown of the budgeted cost for medical in 2009:

NPOS1 single plan		NPOS2 single plan		NPOS1 family plan		NPOS2 family plan	
County Contribution:	\$175.33	County Contribution:	\$175.33	County Contribution:	\$380.88	County Contribution:	\$380.88
Employee Cost:	\$ 9.22	Employee Cost: (credit)	-\$ 6.58	Employee Cost:	\$126.96	Employee Cost:	\$82.71
Total = Actual Plan Cost:	\$184.55	Total = Actual Plan Cost:	\$168.75	Total = Actual Plan Cost:	\$507.84	Total = Actual Plan Cost:	\$463.59