BENEFITS APPLICATION

(Any employee who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is subject to corrective action.)

BROWARD HEALTH®

Employee's Last Name	First	Middle Initial

Employee Number

Select one choice for each of the following:

Medical Plan
- ☐ AETNA BEST CHOICE PPO
- ☐ AETNA SELECT (EPO)
- ☐ AETNA CHOICE POS II (HDHP)
- ☐ Waive Medical Coverage

Type of Coverage:
- ☐ Employee
- ☐ EE + Spouse/DP
- ☐ EE + Child(ren)
- ☐ Family

Dental Plan
- ☐ RELIANCE DENTAL
- ☐ AETNA DENTAL
- ☐ Waive Dental Coverage

Type of Coverage:
- ☐ Employee
- ☐ EE + Spouse/DP
- ☐ EE + Child(ren)
- ☐ Family

Vision Plan
- ☐ Employee
- ☐ EE + Spouse/DP
- ☐ EE + Child(ren)
- ☐ Family
- ☐ Waive Vision Coverage

Type of Deduction
- ☐ Pre tax
- ☐ After tax

Participants to be Covered if Eligible:

	Last Name*	First Name	Social Security Number	Date of Birth	Sex	Comments
Spouse/DP						
Child						
Child						
Child						
Child						
Child						

***You must submit documentation to support eligibility for all dependents: marriage/birth/DP certificiates and social security cards. All documents must be submitted to Human Resources within the required timeframe however, in order to maintain coverage deductions are retroactively taken as of the initial effective date of eligibility. These rules also apply to employees experiencing a qualifying event.**

HUMAN RESOURCE DEPARTMENT ONLY

Effective Date :

Month _____ Day _____ Year _____

- ☐ Marriage/DP _____/_____/_____
- ☐ Birth of Child _____/_____/_____
- ☐ Loss of Coverage (documentation attached)
- ☐ Divorce
- ☐ Add/Delete Dependent

Name: _____ DOB: _____

Name: _____ DOB: _____

- ☐ Other _____

H.R. Representative:

Medical Center: Date:

Tobacco Attestation

Broward Health has established different medical premium rates for employees and their spouse/domestic partner who use tobacco products and those who do not. Additional information, including alternative means for qualifying, is available by contacting Broward Health's EAP Department at 954.847.EAP.

Employee:
- ☐ I certify that I **have** used tobacco products within the last six months
- ☐ I certify that I **have NOT** used tobacco products within the last six months

Spouse/Partner:
- ☐ I certify that I **have** used tobacco products within the last six months
- ☐ I certify that I **have NOT** used tobacco products within the last six months

Short Term and Long Term Disability Insurance

Disability Insurance is available subject to pre-existing condition limitations and additional benefit provisions. Premiums are dependent upon annual base salary.

Check any that apply:

- ☐ **Yes,** I would like to participate in the Short Term Disability plan
- ☐ **Yes,** I would like to participate in the Long Term Disability plan
- ☐ **No,** I would like to waive participation in both Short Term and Long Term Disability

Voluntary Term Supplemental Life Insurance

Voluntary Supplemental Life Insurance is available for employees to purchase additional life insurance for themselves/spouses/domestic partners and dependents. Premiums are based on the amount of coverage/age.

Check any that apply:

- ☐ **Yes,** I would like to participate (please see your Human Resources Department for an Enrollment Form, complete the Enrollment Form, attach to this application and provide the complete package to your Human Resources Department)
- ☐ **No,** I would like to waive participation

I authorize Broward Health to deduct my premiums from my earnings. I understand that my coverage is dependent upon payment of premiums and remaining in an eligible status. I also authorize anyone providing services to me or my dependents to release any information or medical records relating to those services for treatment, payments and healthcare operations to Broward Health and its TPA. All the information above is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____