Benefits Application

[Any employee who knowingly and with intent to harm, defraud or deceive any insurer, or files a statement of claim/application containing any false, incomplete, or misleading information is subject to corrective action.]

Employee Information:	Name (First/Middle/Last):		
Employee #:		HR Rep receiving application:	
Region:	Dept:	Start Date:	☐ Smoker ☐ Non-Smoker
Email Address:		☐ Full-time ☐ Part-time	Mobile #:

Select one choice for each of the following:

MEDICAL PLAN	Coverage Type:	DENTAL PLAN	Coverage Type:	VISION PLAN (choose one)
☐ Aetna Choice/PPO	☐ Employee Only	☐ Aetna DMO	☐ Employee Only	☐ Employee Only
☐ Aetna Select/EPO	☐ Employee & Spouse	☐ Reliance PPO	☐ Employee & Spouse	☐ Employee & Spouse
☐ Aetna POS II/HDHP	☐ Employee & Child/ren		☐ Employee & Child/ren	☐ Employee & Child/ren
	☐ Family		☐ Family	☐ Family
☐ Waive Coverage		☐ Waive Coverage		☐ Waive Coverage

Select Reason for Application:

You must submit documentation to support eligibility for all dependents: *i.e.: marriage/birth certificates/social security cards*. All documentation must be submitted within 30 days of qualifying event. The effective start date of eligibility will be the first of the month following the date of event. These rules apply to all employees experiencing a qualifying event.

☐ **Birth of Child** – copy of birth certificate/SSN required	**Effective Date of Birth:**
☐ **Marriage** – copy of marriage certificate required	**Effective Date of Marriage:**
☐ **Change of Status**: ☐ Full-time to Part-time ☐Part-time to Full-time	**Effective Date of Status Change:**
☐ **Divorce/Legal Separation** – copy of court-ordered decree required	**Effective Date of Divorce:**
☐ **Loss of Coverage** – copy of benefits termination letter required	**Effective Date of Termination of Benefits:**
☐ **Addition/Deletion of Dependent(s)** – supportive documentation required	**Effective Date of Event:**
☐ **Other:**	**Effective Date of Event:**

Eligible Dependents to be covered/Tobacco Attestation:

Broward Health has established different contribution rates for employees and spouses 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 954-847-4327.

	Name (first name/last name)	Social Security #	Date of Birth	Gender	Smoker?
Spouse					☐ Yes ☐ No
Child					☐ Yes ☐ No
Child					☐ Yes ☐ No
Child					☐ Yes ☐ No
Child					☐ Yes ☐ No

Voluntary Plans:

Employees can cancel a voluntary plan at any time **with written request** submitted to their regional Human Resource Department or to Corporate Benefits.

Short Term Disability:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	Disability Insurance is available subject to pre-existing condition limitations and additional benefit provisions. Premiums are dependent upon annual base salary.
Long Term Disability:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	
Supplemental Life Insurance:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	***Please see your HR Department for Enrollment Form.**
Aflac/Critical Care Insurance:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	*** Please see your HR Department for Enrollment Form.**
Aflac/Hospital Indemnity:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	*** Please see your HR Department for Enrollment Form.**
Legal Insurance:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	*** Please see your HR Department for Enrollment Form.**
FSA - Healthcare:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Annual Pledge: $__________________**
FSA - Dependent Care:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Annual Pledge: $__________________**

I authorize Broward Health to deduct my benefit contributions from my earnings. I understand that my coverage is dependent upon payment of amounts are required to remain 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 carriers/TPAs. All the information above is accurate and complete to the best of my knowledge.

Employee Signature: ____ **Date:** ___________________________