

# 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.]

<b>Employee Information:</b>	Name (First/Middle/Last):		
Region:	Employee #:	Start Date:	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker
Email Address:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Mobile #:	

## Select one choice for each of the following plans:

MEDICAL PLAN	Coverage Type:	DENTAL PLAN	Coverage Type:	VISION PLAN (choose one)
<input type="checkbox"/> Aetna Best Choice EPO	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Aetna DMO	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only
<input type="checkbox"/> Aetna Select EPO	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Reliance PPO	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Spouse
<input type="checkbox"/> Aetna POS II HDHP	<input type="checkbox"/> Employee & Child/ren		<input type="checkbox"/> Employee & Child/ren	<input type="checkbox"/> Employee & Child/ren
	<input type="checkbox"/> Family		<input type="checkbox"/> Family	<input type="checkbox"/> Family
<input type="checkbox"/> Waive Coverage		<input type="checkbox"/> Waive Coverage		<input type="checkbox"/> 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.

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

## Eligible Dependents to be covered and Tobacco Attestation:

Broward Health has established different contribution rates for employees and spouses who use tobacco products and those who do not.

Name (first name/last name)	Social Security #	Date of Birth	Gender	Smoker?
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				
Child				
Child				

## 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:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Note: Disability Insurance is available subject to pre-existing condition limitations and additional benefit provisions. Premiums are dependent upon annual base salary.
Long Term Disability:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	
FSA – Healthcare (WageWorks):	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Annual Pledge: \$ _____
FSA - Dependent Care (WageWorks):	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Annual Pledge: \$ _____
Legal Insurance (Code: 9901371)	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Please see your HR Representative for info sheet.
Supplemental Life Insurance:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Reliance Standard Supplemental Life Application must be attached – see HR for info.
Aflac - Critical Care Insurance:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Aflac Application must be attached – see HR for form.
Aflac - Hospital Indemnity:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Aflac Application must be attached – see HR for form.
Aflac – Accident Insurance:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	Aflac Application must be attached – see HR for form.
Home and Auto Insurance:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	<b>Please contact vendor directly for enrollment:</b> Farmers Auto and Home: 1.800.438.6381 Liberty Mutual Auto and Home: 1.800.730.6975
Pet Insurance:	<input type="checkbox"/> Yes, I want to elect.	<input type="checkbox"/> No, I am waiving coverage.	<b>Please contact vendor directly for enrollment:</b> Nationwide Insurance: 1.877.738.7874

I authorize Broward Health to process the above benefit elections and deduct my benefit contributions from my earnings. I understand that my coverage is dependent upon payment of amounts required and to remain in an eligible status. I also understand that failure to submit all required supportive documentation or enrollment applications will be deemed as waiver of benefit.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_