2024 Benefits Application for Qualifying Life Event

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 and/or termination.

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

Select one choice for each of the following plans: Visit: https://employee.browardhealth.org/pages/employee-benefits for detailed benefit information.

MEDICAL PLAN	Coverage Type:	DENTAL PLAN	Coverage Type:	VISION PLAN (choose one)
☐ Aetna **Best Choice** EPO	☐ Employee Only	☐ Aetna DMO	☐ Employee Only	☐ Employee Only
☐ Aetna Select Access 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.** *Other than newborn enrollments*, the effective start date of eligibility will be the first of the month following the date of event.

☐ **Birth of Child** – copy of birth certificate/SSN required	**Effective Date of Birth (DOB):**
☐ **Marriage** – copy of marriage certificate/SSN 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** (please write in)**:**	**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					☐ Yes ☐ No
Child					
Child					
Child					

Voluntary Plans: ***Employees can cancel these voluntary plans at any time with written request submitted to Benefits@browardhealth.org.**

Short Term Disability (for employee only)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Note:** Disability Insurance is subject to pre-existing condition limitations and additional benefit provisions.
Long Term Disability (for employee only)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	
Supplemental Life Insurance:	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Note: Enrollment Form must be attached – see HR for info.**
*** Critical Care Insurance:** *(For Spouse benefit, coverage amount selected cannot exceed 100% of total amount covered by employee – Child coverate is 50% of employee coverage amount.)*	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only **Coverage Amount:** $_____ ☐ **EE & Spouse** **Coverage Amount:** $_____ **Spouse Amount:** $_____ ☐ EE & Child/ren **Coverage Amount:** $_____ ☐ **Family** **Coverage Amount:** $_____ **Spouse Amount:** $_____
*** Hospital Indemnity:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only ☐ EE & Spouse ☐ EE & Child ☐ Family
*** Accident Insurance:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only ☐ EE & Spouse ☐ EE & Child ☐ Family
*** Legal Insurance** (Metlife Legal Plans)**:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**For more info regarding this benefit, please go to:** https://employee.browardhealth.org/pages/employee-benefits
FSA – Healthcare (WageWorks)**:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Annual Pledge:** $_____
FSA - Dependent Care (WageWorks)**:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Annual Pledge:** $_____

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 for employee and/or dependents.

Employee Print Name: _____ **Employee Signature:** _____ **Date:** _____