

COMPANY NAME: Florida Education Association GROUP #: 15093

**BENEFIT ENROLLMENT FORM**



**THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES**

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM  
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

**EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED**

LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
MAILING ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NUMBER		WORK PHONE NUMBER		
ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO (i.e. Medicare, Tricare, spouse's plan)				
IF YES, NAME OF INSURANCE:		EFFECTIVE DATE:		
TYPE OF POLICY (Retiree, COBRA, Spouse):		POLICY HOLDER (Self, Spouse):		
IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A		PART B	HICN	
ENTITLEMENT TO MEDICARE DUE TO: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)				

**EMPLOYER USE ONLY**

DATE OF HIRE	EFFECTIVE DATE
DIVISION #	DEPT. # / CLOCK #
ANNUAL SALARY: \$	
<input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY	
<input type="checkbox"/> NEW ENROLLMENT	
<input type="checkbox"/> Active <input type="checkbox"/> Retiree	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
<input type="checkbox"/> COBRA	
<input type="checkbox"/> ENROLLMENT CHANGE	
<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption	
<input type="checkbox"/> Reinstatement <input type="checkbox"/> Loss of Coverage	
<input type="checkbox"/> Other: _____	
Employer Representative Signature: _____	
Date: _____	

**How healthcare reform affects your plan:**

In March 2010, President Obama signed the Affordable Care Act, or ACA, into law. The ACA, also known as health care reform includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services without any cost sharing.

**Important note:** Dependent coverage is now available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee's biological, step, foster or adopted child (including a child placed for adoption) until such child reaches age 26.

**BENEFIT SELECTION**

COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	PPO (IF APPLICABLE)	COVERAGE LEVEL
<input type="checkbox"/> MEDICAL/RX			<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE
<input type="checkbox"/> DENTAL			<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE

**DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)**

**Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP):** If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:

- a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or  
b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	CHECK COVERAGE	DISABLED DEPENDENT*
					<input type="checkbox"/> MEDICAL/RX <input type="checkbox"/> DENTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL/RX <input type="checkbox"/> DENTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL/RX <input type="checkbox"/> DENTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL/RX <input type="checkbox"/> DENTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL/RX <input type="checkbox"/> DENTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO

\*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION

**COMPANY NAME:** Florida Education Association

**COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS**

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, ☐ FULL TIME ☐ PART TIME SPOUSE EMPLOYER NAME: SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
<input type="checkbox"/> MEDICAL					
<input type="checkbox"/> PRESCRIPTION					
<input type="checkbox"/> DENTAL					
<input type="checkbox"/> VISION					

**COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS**

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐ YES ☐ NO

EMPLOYER PROVIDING COVERAGE:

IF YES, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
<input type="checkbox"/> MEDICAL						
<input type="checkbox"/> PRESCRIPTION						
<input type="checkbox"/> DENTAL						
<input type="checkbox"/> VISION						

\*COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.

**COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, MICHILD, ETC.)**

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	HICN	IS MEDICARE COVERAGE DUE TO:
					<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD
					<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD

**PLAN DECLARATION**

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

**NOTICE OF SPECIAL ENROLLMENT PERIODS**

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you are declining to enroll yourself or an eligible dependent for health coverage because you have (or your dependent has) existing health coverage, your employer may require that you provide a written statement indicating that you are declining coverage because of the existing health coverage. If the employer requires such a statement and notifies you of that requirement, you will receive a separate form to complete and you must complete it to preserve your right to a future special enrollment situation following a loss of that existing coverage.

To request special enrollment or obtain more information, contact your Human Resources representative.

**SIGNATURE AND AUTHORIZATION**

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE