

Coverage Election/Waiver for July 1, 2016

Employer Name: **Currituck County**

PLEASE CHECK FOR YOUR STATUS

- ACTIVE EMPLOYEE
- DUAL EMPLOYEE
- RETIREE
- COROLLA WILD HORSES

Employee #: _____ : Name: _____
 (Last) (Suffix) (First) (MI)

Dual Employee (Spouse) _____

No Changes: **I certify that I am not making any changes to my coverage for 7/1/2016.**

CHECK YOUR ELECTIONS

Medical:		Monthly Premium	Per Pay Check	Election	Waive
8400	Employee Only	---\$0---	---\$0---	_____	_____
2401	Employee/Child	\$192.89	\$96.44	_____	_____
2402	Employee/Children	\$430.84	\$215.42	_____	_____
2403	Employee/Spouse	\$368.46	\$184.23	_____	_____
2400	Family	\$548.65	\$274.32	_____	_____
Dental:					
8401	Employee Only	---\$0---	---\$0---	_____	_____
2702	Employee/Child(ren)	\$9.44	\$4.72	_____	_____
2703	Employee/Spouse	\$28.91	\$14.46	_____	_____
2700	Family	\$36.31	\$18.16	_____	_____
Vision:					
2664	Employee Only	\$6.38	\$3.19	_____	_____
2661	Employee/Child	\$12.22	\$6.11	_____	_____
2662	Employee/Children	\$19.84	\$9.92	_____	_____
2663	Employee/Spouse	\$12.22	\$6.11	_____	_____
2660	Family	\$19.84	\$9.92	_____	_____
Flexible Spending Account:		\$ 3.00 per month per employee		_____	_____
<i>** If electing, complete the reverse side</i>					
Dependent Care:				_____	_____
<i>** If electing complete the reverse side</i>					

Special Enrollment Notice and Certification – Please review and sign below.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am electing and/or declining enrollment as indicated above. I understand that if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that over coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage). I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. In addition, I understand that if I have a newly eligible dependent as the result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I understand that in order to request special enrollment or obtain more information, I should contact my group administrator. **By signing below, I acknowledge that I have received my Summary of Benefits and Coverage (SBC) for my selected plan.**

(Signature of Employee)

(Date of Signature)

FLEX OR DEPENDANT CARE
 Complete the Reverse Side