

# Coverage Election/Waiver for July 1, 2015

**PLEASE CHECK FOR YOUR STATUS**

ACTIVE EMPLOYEE  
 RETIREE  
 WHALEHEAD CLUB  
 COROLLA WILD HORSES

Employer Name: **Currituck County**

Employee #: \_\_\_\_\_ : Name: \_\_\_\_\_  
(Last) (Suffix) (First) (MI)

**Dual Employee (secondary)** \_\_\_\_\_

**No Changes:**  **I certify that I am not making any changes to my coverage for 7/1/2014.**

**CHECK YOUR ELECTIONS**

<b>Medical:</b>		<b>Monthly Premium</b>	<b>Per Pay Check</b>	<b>Election</b>	<b>Waive</b>
FREE	Employee Only	---\$0---	---\$0---	_____	_____
2401	Employee/Child	\$182.46	\$91.23	_____	_____
2402	Employee/Children	\$407.54	\$203.77	_____	_____
2403	Employee/Spouse	\$348.54	\$174.27	_____	_____
2400	Family	\$518.98	\$259.49	_____	_____
<b>Dental:</b>					
FREE	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	_____	_____
<b>Vision:</b>					
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	_____	_____
<b>Flexible Spending Account:</b>		\$ 3.00 per month per employee		_____	_____
<b>Dependent Care:</b>				_____	_____

**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)