

Employee ID _____

Start Date _____

Douglas County BENEFIT ELECTION FORM

Employer Use:	New EE	<input type="checkbox"/>
	Change	<input type="checkbox"/>
EFF Date	_____	

PERSONAL INFORMATION

Last Name		First Name		MI	
SSN		DOB			M / F
Address		City, State		Zip	

Please provide the full legal name(s) for your spouse/dependents.

A dependent age 26-29 may be covered if a Dependent Child Form is also completed.

**A COPY OF THE MARRIAGE LICENSE IS REQUIRED TO COVER YOUR SPOUSE.
A COPY OF THE BIRTH CERTIFICATE IS REQUIRED TO COVER DEPENDENT CHILDREN.**

All Dependent Social Security numbers are required.

If the required documentation is not returned with this form, the dependent coverage will be denied and you will have to wait until the next Open Enrollment to add coverage for the dependent(s).

Spouse		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F
Child Name		DOB		SSN		M / F

GROUP COVERAGE CHOICES

MEDICAL: PPO HDHP HSA Annual Election: _____

*PPO employee only enrollment will occur if no election is indicated.

Employee Only Employee Spouse* Employee Child(ren)* Family Waive

VISION: Employee Only Employee Spouse* Employee Child(ren)* Family Waive

DENTAL COVERAGE: Employee Only Employee Spouse* Employee Child(ren)* Family Waive

LIFE: Employee Optional Life \$_____ (increments of \$10,000) No Extra Life Insurance
Employee may elect \$10,000-\$500,000 max six times salary. Separate sheet for coverage reduction age 65 and older

Spouse Optional Life \$_____ (increments of \$10,000) No Coverage
Minimum \$10,000 up to \$250,000 or ½ employee optional life coverage whichever is less

Child Optional Life 2,000 4,000 6,000 8,000 10,000 No Coverage

BENEFICIARY (IES)

*Per pension rules, a spouse must be listed as your pension beneficiary.

The following will be utilized for all coverages you elect, unless otherwise noted in the comment section.

Name		Relationship		%	
Street Address					
Name		Relationship		%	
Street Address					
Name		Relationship		%	
Street Address					
Name		Relationship		%	
Street Address					

Comments:

AGREEMENT

1. You are enrolled in the Douglas County Employee Retirement Plan and deductions will be take based on plan rules.
2. By submitting this application, you authorize Douglas County to enroll your benefits and deduct premiums according to the information you have supplied. Changes to pre-tax benefits may only occur within 31 days of a qualifying event with proper documentation. If you no longer meet eligibility requirements, your insurance elections will be cancelled.
3. I herby apply for the insurance for which I am now or may become eligible under the group policy or policies issued to the policyholder and hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance. This authorization may be revoked by me at anytime by written notice to the policyholder. If my employment is terminated, on re-employment no insurance will become effective until I again apply for insurance in accordance with the terms of the group policy.

SIGNATURE

Signature		Date	
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