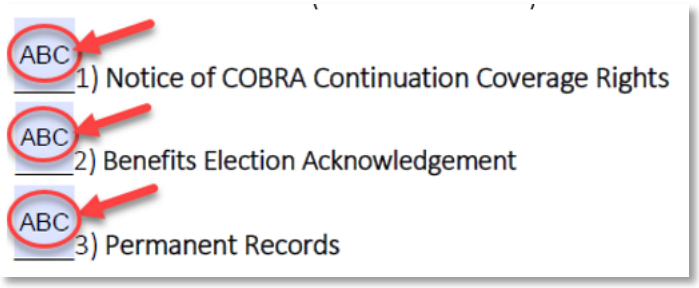
INSTRUCTIONS: BENEFITS ACKNOWLEDGEMENT FORM

Please complete the form in its entirety. Incomplete forms will be sent back for corrections.

HOW TO COMPLETE THE FORM:

- **Download/Save** this form to your computer. Save as "EEID Name Benefits Acknowledgement Form".
- Please **initial** all **3** boxes (do not check off)



- **The first box** brings attention to your COBRA rights. If or when you leave the County, you will be offered COBRA or the opportunity to continue your benefits without the County contribution. Additional information, rates, and timing details can be found in your Employee Benefits Handbook.
- **The second box** serves as your certification that you understand the 30-day deadline to submit your new hire election documentation and forms. If you fail to submit the required documentation by the deadline, you will be automatically be enrolled in County CORE coverage.
- **The third box** is for records purposes. You are confirming that you understand that this document will be kept in your permanent records file.
- Don't forget to insert your **name, EEID, electronic signature,** and **date** the bottom of the form.
    - Click review and sign link in email.
    - Click prompt in document.
    - Create signature.
    - Select signature option.
    - Sign document.
    - Finalize signature.
    - Send.

SUBMISSION PROCESS:

- Submit your completed form to the secure Box.com folder on or before your start date.
- Refer to our Upload Documentation webpage for additional information.

NEED HELP?

- If you need help completing this form please reach out to Benefits@ocfl.net

Benefits Acknowledgements

Please complete the following benefits acknowledgements by reviewing and initialing each of the three lines below:

____1) **Notice of COBRA Continuation Coverage Rights**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under this law, the Orange County Board of County Commissioners (OCBCC) is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the plan would otherwise end due to certain qualifying events.

I acknowledge receiving my **initial COBRA notification**, which can be found in the **Important Information section** of my benefits handbook, on the date indicated below. This notification outlines any potential rights and obligations under the Federal COBRA law to me and my covered family members (if any). I understand failure to make my spouse (if any) aware of this notification letter may result in a loss of potential COBRA rights for my dependents.

____2) **Benefits Election Acknowledgement**

I understand that I have 30 calendar days from my date of hire to make my benefits elections. If I fail to submit my elections to the Benefits Department within 30 days of that date, I will be enrolled in core benefits. Core medical is the high deductible health plan coverage for the employee only. I understand that I will not be able to change this election until the next open enrollment period unless I have a qualifying event (i.e. marriage, divorce, birth, etc.). I understand that my benefit elections will become effective after all required enrollment documentation has been received and processed.

____3) **Permanent Records**

I understand this form will be part of my permanent records retained in my Personnel file. I further understand that I can request a copy of my employee records by contacting HRIS.Records@ocfl.net.

Print Name_____ Employee ID_____

Employee Signature_____ Date_____

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Reset Form