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) **Benefits Coverage Effective Date Acknowledgement**

I hereby acknowledge that I have been provided the link to the Orange County Employee Benefits webpage (New Hire Benefits Webpage) that includes a copy of the Employee Benefits Handbook.

By signing this document, I recognize that I am a regular full or part-time employee who is scheduled to work 20 hours or more per week) and I am currently eligible for the group insurance plans offered under the Wellness for Life Plan.

I acknowledge that I have received, read, and understand the enrollment and eligibility rules associated with Orange County Governments, Wellness For Life Plan's Employee Benefits Handbook, which outlines the below listed benefits eligibility and effective dates for the current plan year.

- ☐ I understand that I will be ***enrolled in*** the following coverage effective the date of hire: Basic Life Insurance and AD&D, Long Term Disability, Employee Assistance Program and Florida Retirement System (FRS).
- ☐ I understand that I am ***eligible for*** the following additional coverage effective the date of hire. Medical (with or without HSA*), Short Term Disability, Dental, Child Life Insurance, Vision, Supplemental Life and AD&D, Spouse Life Insurance, Flexible Spending Accounts, and the Deferred Compensation 457(b) Plan. *Special rules apply for HSAs.

  NOTE: *Although I am eligible for coverage effective date of hire, I acknowledge that my coverage will not begin until approved by the Administrator, but not earlier than the first pay period beginning after the Election form is completed, returned to, and processed by the Administrator. This shall not terminate any eligibility rights provided under applicable federal law (e.g., birth or adoption of child) or termination of participation rules under Section 3.04 of this plan document.*
- ☐ I understand that my healthcare benefits, through Orange County Government, will not be prorated, and that I am paying for my benefits on a per pay period basis, regardless of my benefits effective date.

____4) **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 HR.Records@ocfl.net.

Print Name_____ Employee ID_____

Employee Signature_____ Date_____