

# INSTRUCTIONS: BENEFITS ENROLLMENT FORM

This enrollment form is used to select your new or change your existing healthcare coverage at the County.

- **New Employees:** Please complete this form within 30 days of your date of hire. *Be sure to include applicable dependent documentation.*
- **Existing Employees:** All qualified life events must be submitted online via [myOCportal](#) within 60 days of the event. If unable to submit your Life Event request online, please be sure to reach out to [Benefits@ocfl.net](mailto:Benefits@ocfl.net) for assistance. *Paper enrollment forms will not be accepted without a prior authorization.*
- **Open Enrollment:** If you were on leave during the entire open enrollment period, please complete this form within 30 days of your return. *Be sure to include applicable dependent documentation.*

For additional information, refer to your [Employee Benefits Handbook](#). If you have questions or need assistance, contact us at [Benefits@ocfl.net](mailto:Benefits@ocfl.net) or (407) 836-5661.

## IMPORTANT INFORMATION – GLOSSARY TERMS:

**Action-No Change:** Check this box if you would like Current coverage to remain as is

**Action-Elect Coverage:** Check this box to begin initial enrollment (no coverage currently exists)

**Action-Waive Coverage:** Check this box if you do not want coverage at all

**Action-Add/Remove Dependents:** Check this box if you have existing coverage but would like to add or remove covered dependents.

**EEID:** Employee ID Number

**EE Only:** Employee Only

**EE + SP:** Employee + Spouse

**EE + CH:** Employee + Child(ren)

**EE + Family:** Employee + Spouse + Children

**EE + 1:** Employee + 1 Dependent

**EE + 2 or more:** Employee + 2 or more Dependents

**Dependent:** Eligible family members as defined in your Employee Benefits Handbook.

**HDHP:** High Deductible Health Plan

**LDHP:** Low Deductible Health Plan

**STD:** Short Term Disability

**FSA:** Flexible Spending Account

**HSA:** Health Savings Account

**Medical Underwriting:** Evidence of insurability

## HOW TO COMPLETE THE FORM:

**Download/Save** this form to your computer. Save as “EEID\_Last Name\_Benefits Enrollment Form”.

In the **Employee Information** section, please enter the following:

- Last Name (as it appears on your Social Security Card)
- First Name (as it appears on your Social Security Card)
- Employee ID
- Division/Department
- Cell Phone Number (personal)
- Email (personal)

EMPLOYEE INFORMATION		
<div style="text-align: center; color: red; font-weight: bold; margin-bottom: 5px;">★</div> Last Name	<div style="text-align: center; color: red; font-weight: bold; margin-bottom: 5px;">★</div> First Name	<div style="text-align: center; color: red; font-weight: bold; margin-bottom: 5px;">★</div> Employee ID
<div style="text-align: center; color: red; font-weight: bold; margin-bottom: 5px;">★</div> Division/Department	<div style="text-align: center; color: red; font-weight: bold; margin-bottom: 5px;">★</div> Phone Number	<div style="text-align: center; color: red; font-weight: bold; margin-bottom: 5px;">★</div> Email Address

Under **Enrollment Type**, complete the following:

- **Select One:** Check off New Hire, Open Enrollment, or Qualified Event. For qualified event, select applicable option from the drop-down menu. *\*Qualified events should be completed online; Paper enrollment forms will not be accepted without a prior authorization.*
- **Event Date:**
  - **New Employees:** Your date of hire.
  - **Existing Employees:** The date of your qualified event
  - **Open Enrollment:** Your return to work date.
- **Effective Date:** Leave this blank

<b>ENROLLMENT TYPE</b> <i>(select one):</i> <input checked="" type="checkbox"/> New Hire <input checked="" type="checkbox"/> Open Enrollment <input checked="" type="checkbox"/> Qualified Event <input checked="" type="checkbox"/> <b>Select One (QE Only)</b>	<b>EVENT DATE:</b> <input type="text"/>	<b>EFFECTIVE DATE:</b> <input type="text" value="Leave Blank"/>
<i>(Bi-Weekly rates listed in Benefits Handbook)</i>		

Next, make your enrollment selections. Be sure to complete each section in its entirety and pay close attention to additional information provided in the various sections. Incorrect or incomplete forms will be sent back for corrections and may delay the effective date of your coverage.

**Medical:** *(Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect”, “Waive”, or “Add/Remove Dependents”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Dependent:** Select one. “EE only”, “EE + SP”, “EE + CH”, or “EE + Family”
- **Plan Option:** Select one. “OrangePrime Plus (HDHP)”, “OrangePrime (LDHP)”, or “Tricare Supplement”

<b>MEDICAL</b>	<b>Action</b> <input checked="" type="checkbox"/>	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Add/Remove Dependents
	Dependent <input checked="" type="checkbox"/>	<input type="checkbox"/> EE Only	<input type="checkbox"/> EE + SP	<input type="checkbox"/> EE + CH	<input type="checkbox"/> EE + Family
	Plan Option <input checked="" type="checkbox"/>	<input type="checkbox"/> OrangePrime Plus (HDHP)	<input type="checkbox"/> OrangePrime (LDHP)	<input type="checkbox"/> TRICARE Supplement	

**Dental:** *(Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect”, “Waive”, or “Add/Remove Dependents”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Dependent:** Select one. “EE only”, “EE + 1”, or “EE + 2 or more”
- **Plan Option:** Select one. “Low Plan”, “Middle Plan”, or “High Plan”

<b>DENTAL</b>	<b>Action</b> <input checked="" type="checkbox"/>	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Add/Remove Dependents
	Dependent <input checked="" type="checkbox"/>	<input type="checkbox"/> EE Only	<input type="checkbox"/> EE + 1	<input type="checkbox"/> EE + 2 or more	
	Plan Option <input checked="" type="checkbox"/>	<input type="checkbox"/> Low Plan	<input type="checkbox"/> Middle Plan	<input type="checkbox"/> High Plan	

**Vision:**

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect”, “Waive”, or “Add/Remove Dependents”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Dependent:** Select one. “EE only”, “EE + 1”, or “EE + 2 or more”

<b>VISION</b>	<b>Action</b> <input checked="" type="checkbox"/>	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Add/Remove Dependents
	Dependent <input checked="" type="checkbox"/>	<input type="checkbox"/> EE Only	<input type="checkbox"/> EE + 1	<input type="checkbox"/> EE + 2 or more	

**Additional Life:** (Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect Coverage”, or “Waive Coverage”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Total Amount:** Enter total amount of coverage wanted. Leave blank if waiving coverage.
- **Medical Underwriting:** Check box if applicable.

ADDITIONAL LIFE	<b>Action</b> ★	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	★ Medical Underwriting Required (see benefits handbook for rules)
	Basic Life equal to your annual salary (county paid)	Total Amount \$ ★ (increments of \$10,000)			
		* Supplemental life up to 5x your annual salary (Plan Max \$300,000)			

**Spouse Life:** (Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect Coverage”, or “Waive Coverage”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Total Amount:** Enter total amount. Leave blank if waiving coverage.
- **Medical Underwriting:** Check box if applicable.

SPOUSE LIFE	<b>Action</b> ★	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	★ Medical Underwriting Required (see benefits handbook for rules)
	Cannot exceed employee basic + additional life	Total Amount \$ ★ (increments of \$10,000)			
		* Plan Max \$250,000			

**Child Life:** (Refer to your Employee Benefits Handbook for more information about this benefit)

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect”, “Waive”, or “Add/Remove Dependents”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Total Amount:** Select \$5,000 or \$10,000. Leave this section blank if waiving coverage.

CHILD LIFE	<b>Action</b> ★	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Add/Remove Dependents
	Children can only be covered by one employee	Total Amount ★ <input type="checkbox"/> \$5,000		<input type="checkbox"/> \$10,000	

**Short Term Disability:** (Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect Coverage”, or “Waive Coverage”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Amount:** Select 15, 30, 60, 90, or 120 Day Wait period. Leave this section blank if waiving coverage.
- **Medical Underwriting:** Check box if applicable.

STD	<b>Action</b> ★	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage	★ Medical Underwriting Required (see benefits handbook for rules)
	<b>Amount</b> ★	<input type="checkbox"/> 15-Day Wait	<input type="checkbox"/> 60-Day Wait	<input type="checkbox"/> 120-Day Wait	
		<input type="checkbox"/> 30-Day Wait	<input type="checkbox"/> 90-Day Wait		

**Flexible Spending Account:** (Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect Coverage”, or “Waive Coverage”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Deduction:** Enter deduction amount. Leave blank if waiving coverage
- **Plan Option:** Choose one. “Medical” or “Limited Purpose”

FSA	Action	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage
	Deduction	Deduct \$  per pay period (\$15 minimum)		
	Plan Option	<input type="checkbox"/> Medical <i>*available if HSA is not elected</i>	<input type="checkbox"/> Limited Purpose <i>*Dental/Vision expenses only</i>	

**Dependent Care Flexible Spending Account:** (Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)

- **Action:** Select one
  - **New Employees:** Choose “Elect” or “Waive” coverage.
  - **Existing Employees:** Choose “No Change”, “Elect Coverage”, or “Waive Coverage”
  - **Open Enrollment:** Choose “Elect” or “Waive” coverage.
- **Deduction:** Enter deduction amount. Leave blank if waiving coverage

DEP CARE	Action	<input type="checkbox"/> No Change	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Waive Coverage
	Deduction	Deduct \$  per pay period (\$15 minimum)		

**Health Savings Account:** (Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)

- Select one
  - Check “HSA Election Form Attached” if you would like to have an HSA account.
  - Check “N/A” if you do not qualify for or do not want an HSA.

HSA	<i>Only available if electing the OrangePrime Plus plan (HDHP)</i>	<input type="checkbox"/> HSA Election Form Attached (required for HSA Participation)
		<input type="checkbox"/> N/A I do not qualify for or do not want an HSA

**Reminder:** If you are selecting an HSA, you must also complete the [HSA Election Form](#) and [open your account](#). In the **Dependent Information** section, add all family members to be covered on Medical, Dental, Vision, and/or Life insurance.

**Spouse:** If you are adding your spouse to coverage you must complete this section. Leave it blank if not applicable.

- Check off “Spouse” and input “Marriage Date”
- Input “Last Name, First Name” (as listed on your spouse’s social security card)
- Input “Date of Birth”
- Input “Social Security Number”
- Select appropriate “Gender”
- Check off “Spouse Life” if you selected “Spouse Life” insurance on page one. Leave it blank if not applicable
- Medical: Select one. “Elect” or “Waive”
- Dental: Select one. “Elect” or “Waive”
- Vision: Select one. “Elect” or “Waive”

<b>Dependent information: List all family members to be covered and only select coverage type desired.</b>								
<i>* Include copies of all required dependent documentation as outlined in your current benefits handbook</i>								
Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
Spouse <i>Marriage Date:</i>				<input type="checkbox"/> M <input checked="" type="checkbox"/> F	Spouse Life	<input checked="" type="checkbox"/> Elect <input type="checkbox"/> Waive	<input checked="" type="checkbox"/> Elect <input type="checkbox"/> Waive	<input checked="" type="checkbox"/> Elect <input type="checkbox"/> Waive

**Child/Grandchild:** If adding your child/grandchild to coverage you must complete this section.

- Check off “Child” or “Grandchild”
- Input “Last Name, First Name” (as listed on your child/grandchild’s social security card)
- Input “Date of Birth”
- Input “Social Security Number”
- Select appropriate “Gender”
- Check off all that apply: “Disabled”, “Court Order”, or “Child Life” Leave it blank if not applicable
- Medical: Select one. “Elect” or “Waive”
- Dental: Select one. “Elect” or “Waive”
- Vision: Select one. “Elect” or “Waive”

Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
<input checked="" type="checkbox"/> Child	★	★	★	<input checked="" type="checkbox"/> M	<input checked="" type="checkbox"/> Disabled	<input checked="" type="checkbox"/> Elect	<input checked="" type="checkbox"/> Elect	<input checked="" type="checkbox"/> Elect
<input checked="" type="checkbox"/> Grandchild				<input type="checkbox"/> F	<input checked="" type="checkbox"/> Court Order	<input type="checkbox"/> Waive	<input type="checkbox"/> Waive	<input type="checkbox"/> Waive
					<input checked="" type="checkbox"/> Child Life			

Be sure to read your **Notice of Enrollment Rights** on page two. When you sign your election form, you are acknowledging and consenting to the information provided.

**Sign & Date:** Don’t forget to insert your signature or sign your name, add your employee ID number, and date the bottom of your enrollment form.

**Please note, your requested plan change(s) will take 1-2 pay periods to be processed and become visible to you in applicable systems.**

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Employee Signature	EEID	Date

**SUBMISSION PROCESS:**

- Submit your completed form to the [secure Box.com folder](#)
- Refer to our [Upload Documentation webpage](#) for additional information

**NEED HELP?**

For additional information, refer to your [Employee Benefits Handbook](#). If you have questions or need assistance, contact us at [Benefits@ocfl.net](mailto:Benefits@ocfl.net) or (407) 836-5661