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 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 or (407) 836-5661.

IMPORTANT INFORMATION – GLOSSARY TERMS:

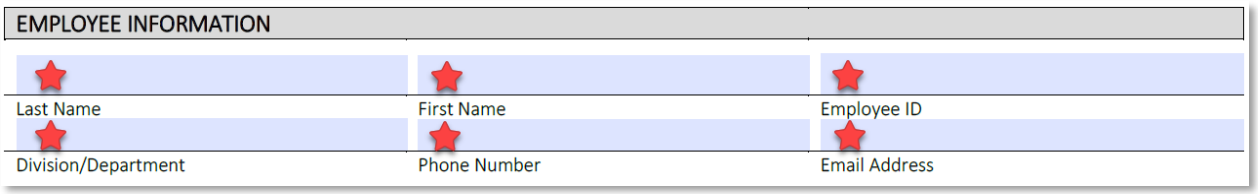
Action-No Change: Check this box if you would like Current coverage to remain as is
Action-Elect Coverage: Check this box to begin initial enrollment (no coverage currently exists)
Action-Waive Coverage: Check this box if you do not want coverage at all
Action-Add/Remove Dependents: Check this box if 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".

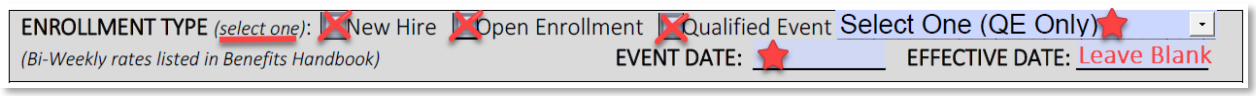
In the **Employee Information** section, please enter the following:

- 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)



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



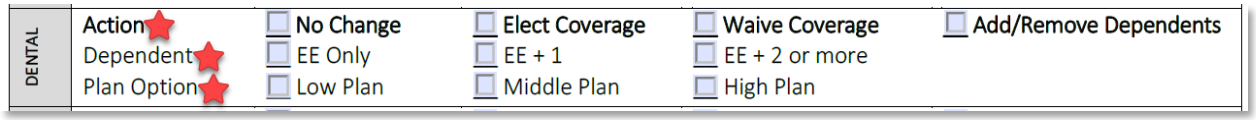
Next, make your enrollment selections. Be sure to complete each section in its entirety and pay close attention to additional information provided in the various sections. Incorrect or incomplete forms will be sent back for corrections and may delay the effective date of your coverage.

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"

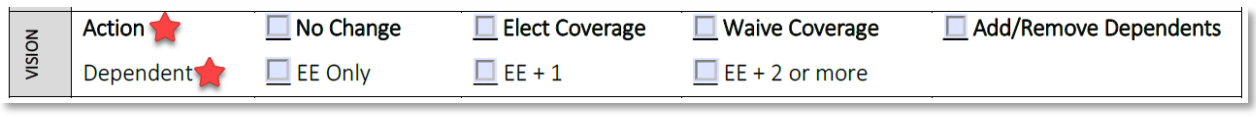
Dental: (*Refer to your Employee Benefits Handbook for more information, including handy comparison charts.)*

- **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"



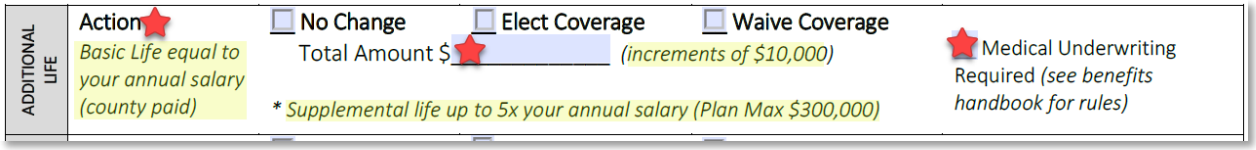
Vision:

- **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 "



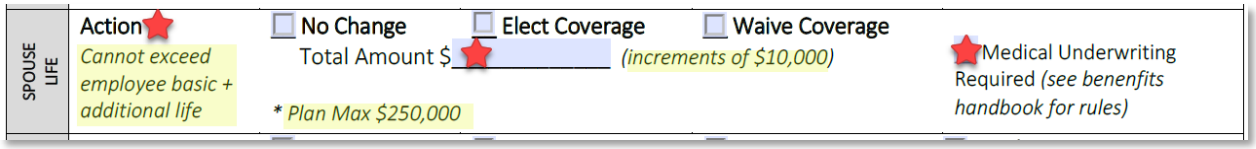
Additional Life: (*Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)*

- **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.



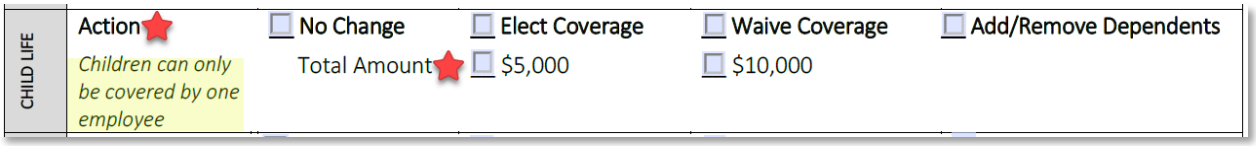
Spouse Life: (*Refer to your Employee Benefits Handbook for more information about this benefit and/or medical underwriting rules.)*

- **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.



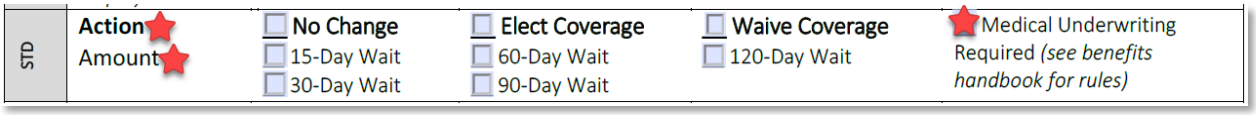
Child Life: (*Refer to your Employee Benefits Handbook for more information about this benefit)*

- **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.



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.



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 ★	☐ No Change	☐ Elect Coverage	☐ Waive Coverage
Deduction	Deduct $ ★ _____ per pay period ($15 minimum)		
Plan Option ★	☐ Medical **available if HSA is not elected*	☐ Limited Purpose **Dental/Vision expenses only*	

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 ★	☐ No Change	☐ Elect Coverage	☐ 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		
Only available if electing the OrangePrime Plus plan (HDHP) ★	☐ HSA Election Form Attached (required for HSA Participation)	
	☐ 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.

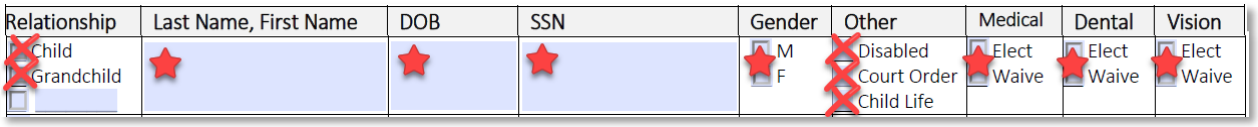
- Check off "Spouse" and input "Marriage Date"
- Input "Last Name, First Name" (as listed on your spouse's social security card)
- Input "Date of Birth"
- Input "Social Security Number"
- Select appropriate "Gender"
- Check off "Spouse Life" if you selected "Spouse Life" insurance on page one. Leave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

Dependent information: List all family members to be covered and only select coverage type desired.
** Include copies of all required dependent documentation as outlined in your current benefits handbook*

Relationship	Last Name, First Name	DOB	SSN	Gender	Other	Medical	Dental	Vision
☐ Spouse *Marriage Date:* ★	★	★	★	☐ M ☐ F ★	☐ Spouse Life	☐ Elect ☐ Waive ★	☐ Elect ☐ Waive ★	☐ Elect ☐ 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"



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.

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 or (407) 836-5661