Part A

Kent County Benefit Election Form

Dept. Name: _____ Date of Event: ___/___/___ Effective Date: ___/___/___ *(H.R. Use Only)* Privacy No.: _____ *(H.R. Use Only)*

☐ New Hire ☐ Rehire ☐ Beneficiary Change ☐ Loss of Other Coverage* ☐ Change to Full-Time ☐ Marriage* ☐ Divorce*

☐ Birth/Adoption* ☐ Termination* ☐ Add Dependent(s)* ☐ Delete Dependent(s)* ☐ Other _____

*Documentation Necessary

Date of Hire

Employee #

Marital Status ☐ Single ☐ Married

Employee Social Security No.	Employee Last Name	Employee First Name	M.I.	Sex	Birthdate	Work Phone

Home Address	City	State	Zip	Home Phone

Employee Coverage Elected — Med & Rx ☐ Den ☐ Vis ☐

List all dependents below (To add or delete dependents, include only name of individual being changed, all others remain as is.)

Check One	Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No. (Required)	Relationship	Dep. Coverage Elected Med & Rx	Den	Vis
Spouse Add ☐ Delete ☐								☐	☐	☐
Dep-1 Add ☐ Delete ☐								☐	☐	☐
Dep-2 Add ☐ Delete ☐								☐	☐	☐
Dep-3 Add ☐ Delete ☐								☐	☐	☐
Dep-4 Add ☐ Delete ☐								☐	☐	☐
Dep-5 Add ☐ Delete ☐								☐	☐	☐
Dep-6 Add ☐ Delete ☐								☐	☐	☐
Dep-7 Add ☐ Delete ☐								☐	☐	☐
Dep-8 Add ☐ Delete ☐								☐	☐	☐

Medical & Prescription Coverage

	Single	Double	Family
Waive Coverage ☐			
BCBS Wellness Plan PPO & Capital Rx	☐	☐	☐
BCN Wellness Plan HMO & Capital Rx	☐	☐	☐
BCBS High Deductible Plan & Capital Rx	☐	☐	☐

☐ I am adding or waiving coverage for myself and my spouse or parent is currently employed by Kent County.

☐ I am covering a spouse and/or dependent that is currently employed by Kent County.

Dental Coverage

☐ ***Waive Coverage***

Single ☐ Double ☐ Family ☐

Varipro

Vision Coverage

☐ ***Waive Coverage***

Single ☐ Double ☐ Family ☐

Vision Service Plan

I understand that the above benefit elections may only be used for myself or my dependents as defined under the plan. My benefit elections will remain in effect for the entire plan year, unless I experience a change in my family status. I also understand that I must notify Human Resources within 30 days of the event in order to change my benefit elections. I hereby authorize Kent County to deduct my employee contribution towards the cost of monthly health insurance premiums from my bi-weekly earnings.

Signature: _____ **Date:** _____

Waiver (Medical & Prescription Coverage) I wish to waive my medical and prescription benefits. I understand that I will be unable to enroll in medical or prescription benefits until the next Open Enrollment period unless I experience a change in my family status. I understand that this waiver will become effective the first of the month following receipt of this form by Human Resources. Should I choose to elect coverage during Open Enrollment, my elections will not become effective until January 1st, the beginning of the next plan year.

Signature: _____ **Date:** _____

Rev. 5/19

Part B

Kent County Life Insurance Beneficiary Form

☐ New Election

☐ Change of Beneficiary

Basic Life & AD&D: *(County Provided)*
(H.R. Use Only)
Life Insurance Amount: $____________________

Voluntary Supplemental Life:

Supplemental Life Insurance Amount: $____________________

☐ ***Coverage Elected*** ☐ ***No Coverage Elected***

Note: Amount of coverage determined by employment group

Supplemental Life

Insurance Benefit $ ______________
Divide by 1,000 ______________
Times rate ______________
Monthly Cost = $ ______________

AGE	Rate per $1,000
<29	.057
30 – 34	.067
35 – 39	.076
40 – 44	.114
45 – 49	.209
50 – 54	.371
55 – 59	.646
60 – 64	1.245
65 +	2.271

Employee Social Security No.	Employee Last Name	Employee First Name	M.I.	Sex	Birthdate	Work Phone	Date of Hire

Home Address	City	State	Zip	Home Phone	Employee #

Dependent Life Insurance: *(Management Pay Plan Employees, Judges/Elected, & Commissioners only)*

Dependent Life Insurance Benefit: **Spouse** - $25,000 **Child** - up to age 19 *or 25 if full time student* - $10,000. Monthly cost is $3.75 per family unit.

☐ ***Coverage Elected*** ☐ ***No Coverage Elected*** ☐ Spouse ☐ Dep-1 ☐ Dep-2 ☐ Dep-3 ☐ Dep-4

Beneficiary Information ***(Note: % of benefit totals for beneficiaries must equal 100%)***

Primary Beneficiary Last Name	Primary Beneficiary First Name	Beneficiary Social Security No.	Phone	Date of Birth	Basic % Benefit	Supplemental % Benefit

Home Address	City	State	Zip	Relationship

Primary Beneficiary Last Name	Primary Beneficiary First Name	Beneficiary Social Security No.	Phone	Date of Birth	% Benefit	% Benefit

Home Address	City	State	Zip	Relationship

Primary Beneficiary Last Name	Primary Beneficiary First Name	Beneficiary Social Security No.	Phone	Date of Birth	% Benefit	% Benefit

Home Address	City	State	Zip	Relationship

Primary Beneficiary Last Name	Primary Beneficiary First Name	Beneficiary Social Security No.	Phone	Date of Birth	% Benefit	% Benefit

Home Address	City	State	Zip	Relationship

Contingent Beneficiary Last Name	Contingent Beneficiary First Name	Beneficiary Social Security No.	Phone	Date of Birth	% Benefit	% Benefit

Home Address	City	State	Zip	Relationship

Contingent Beneficiary Last Name	Contingent Beneficiary First Name	Beneficiary Social Security No.	Phone	Date of Birth	% Benefit	% Benefit

Home Address	City	State	Zip	Relationship

I understand that the above elections are binding, and I am authorizing Kent County to deduct any premiums for coverage from my earnings. I understand that if I waive any of the above coverage I will be unable to change my elections until the next Open Enrollment period unless I experience a change in my family status. Should I fail to modify my beneficiary designations during the course of my tenure with Kent County, the County will distribute the proceeds of any life insurance policy to the beneficiaries according to the latest beneficiaries listed.

If I am enrolling in Supplemental life I understand: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absences on the date that insurance would otherwise become effective.

If I am enrolling in Dependent Life I understand: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

Signature: ______________________________ **Date:** ____________________