Kaufman County
Employee Benefits Enrollment Form 2022-2023

Reason For Completing This Form

☐ New Employee Date of Hire: _____ ☐ Divorce ☐ Death of Spouse or Child ☐ Spouse/Child Loss of Coverage

☐ Rehire Date of Rehire: _____ ☐ Birth or Adoption of Child ☐ Legal Separation ☐ Spouse/Child Gain Coverage

☐ Marriage ☐ Change of Beneficiary ☐ Dependent over age limit ☐ Other:

Employee Information

Last Name_____ First Name_____ MI _____

Address_____ City_____ State_____ ZIP _____

Home Phone Number (_____)_____ Work Phone Number (_____)_____ Date of Birth: (mm/dd/yy) _____

E-mail Address_____ Social Security Number_____-_____-_____ Employee # _____

Base Salary_____ Occupation _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married Number of Dependents: _____

Medical (includes Prescription Coverage) – *Blue Cross Blue Shield*

Employee Cost per month

Plan Selection	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family
BCBS 1200NGS Plan	☐ $0	☐ $755.16	☐ $230.34	☐ $419.96	☐ $840.64
☐ Waive Coverage with Kaufman County Group Health Insurance (must provide verification of other coverage)					

Dental – Blue Cross Blue Shield

Employee Cost per month

Plan Selection	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive Coverage
BCBS	☐ $27.88	☐ $55.02	☐ $60.86	☐ $89.98	☐

Vision – *Superior Vision*

Employee Cost per month

Plan Selection	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive Coverage
Superior Vision	☐ $4.82	☐ $8.16	☐ $8.66	☐ $12.98	☐

Dependent Information

Complete the following information for the enrollment of dependents.

Name (Last, First, Middle Initial)	Gender Male or Female	Relationship to Employee (Spouse, Child, Stepchild)	Date of Birth (mm/dd/yyyy)	SS# REQUIRED
Spouse	☐ M ☐ F			
Dependent	☐ M ☐ F			
Dependent	☐ M ☐ F			
Dependent	☐ M ☐ F			
Dependent	☐ M ☐ F			
Dependent	☐ M ☐ F			

If you have more than six dependents, please complete an additional enrollment form.

Coordination of Benefits

Do you or any of your covered dependents have any other insurance coverage? □ NO □ YES IF YES:

Dependent Name	Insurance Company	Plan Number	Company
Dependent Name			

Basic Term Life Insurance and Accidental Death & Dismemberment (AD&D) – *The Lincoln National Life Insurance Company*

Kaufman County pays 100% of the premium to provide Term Life and Accidental Death & Dismemberment benefits for each employee. Benefit amount is 1 X your base annual salary up to $150,000. The County also provides a flat benefit for spouse ($5000) and children up to the age of 25 ($2500). Plan pays according to Summary Plan Document. Limitations and exclusions may apply.

Supplemental Life Insurance/AD&D (Available to you and your eligible dependents) – *The Lincoln National Life Insurance Company*

You have the option to elect Supplemental Life Insurance in $10,000 increments up to 5 times your annual base salary or a maximum of $500,000. If your election is greater than $200,000, you must complete an Evidence of Insurability Form.

Employee Life Amount: (check one): □ **$10,000** □ **$20,000** □ **$30,000** □ **$40,000** □ **$50,000** □ **$60,000** □ **$70,000** □ **$80,000** □ **$90,000** □ **$100,000** □ **$110,000** □ **$120,000** □ **$130,000** □ **$140,000** □ **$150,000** □ **$160,000** □ **$170,000** □ **$180,000** □ **$190,000** □ **$200,000** □ **Other $_____** □ **Waive Coverage**

$_____ x _____ ÷ $1000 = _____ x _____ ÷ _____ = _____

(Amount of coverage) (rate factor by age-see below) monthly deduction # months # of pp per pay period

You have the option to elect Supplemental Life Insurance for your Spouse. Choose from $10,000 up to $250,000, in increments of $5,000. Amounts exceeding $30,000 will require an Evidence of Insurability Form to be completed by your spouse. Employee must be enrolled in a minimum of $10,000 in order to have Supplemental Spouse Life Insurance. Spouse cannot exceed 50% of employee's election amount.

Spouse Life Amount: (check one): □ **$10,000** □ **$15,000** □ **$20,000** □ **$25,000** □ **$30,000** □ **Other $_____** □ **Waive Coverage**

$_____ x _____ ÷ $1000 = _____ x _____ ÷ _____ = _____

(Amount of coverage) (rate factor by age-see below) monthly deduction # months # of pp per pay period

Name of Spouse: _____ **Spouse Date of Birth:** _____ (mm/dd/yyyy)

Employee must be enrolled in a minimum of $10,000 in order to have Dependent Life Insurance.

Dependent Child(ren) Life Amount (Dependents to age 25): □ **$10,000** □ **Waive Coverage**

$ 2.00 child coverage x _____ ÷ _____ = _____

Monthly Cost # months # of pp per pay period

Statement of Health not required. Please note that changes to the amount of coverage may not be made during the plan year unless applicable with a Qualifying Event.

Dependent Information

Name (Last, First, Middle Initial)	Gender Male or Female	Relationship to Employee (Spouse, Child, step-child)	Date of Birth (mm/dd/yyyy)	SS# REQUIRED
Dependent	□ M □ F			
Dependent	□ M □ F			
Dependent	□ M □ F			
Dependent	□ M □ F			
Dependent	□ M □ F			

Supplemental Life Insurance/AD&D Rates – *The Lincoln National Life Insurance Company*

AGE RATED PREMIUMS (Rates based on Employee's Age)	(Rate Per $1,000)
Life Rate: Up to 24	$0.08
25-29	$0.08
30-34	$0.08
35-39	$0.11
40-44	$0.16
45-49	$0.23
50-54	$0.41
55-59	$0.63
60-64	$0.70
65-69	$1.22
70-74	$3.02
75-79	$7.75
80+	$15.53
Child Life Rate ($10,000)	$2.03

Beneficiary Designation for Basic Life, AD&D and if applicable Supplemental Life Insurance

Payment will be made in equal shares up to 100% or all to the survivor unless otherwise indicated. If no beneficiaries survive you, or none are named, benefits will be payable to your estate.

Primary Beneficiary Full Name	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Alternate Beneficiary Full Name	**Relationship**	**Date of Birth**	**Address (Street, City, State, Zip)**	**Share %**

Long Term Disability – *The Lincoln National Life Insurance Company*

Long Term Disability benefit is equivalent to 60% of your monthly earnings up to a maximum monthly benefit of $6,000. Elimination period of 90 days. Maximum benefit duration is the later of age 65 or Social Security Normal Retirement Age (SSNRA).

Long Term Disability Plan	
$_____÷ 12 = _____ ÷ 100 = _____ x _____= _____ x_____÷_____= _____ (Base Annual Salary) monthly salary (rate factor) monthly cost # months # of pp per pay period	☐ **Waive Coverage**

AGE RATED PREMIUMS	Rate per $100 of Base Monthly Salary
< 30	0.15
30-34	0.25
35-39	0.43
40-44	0.65
45-49	0.92
50-54	1.18
55-59	1.50
60-64	1.26
65-69	0.98
70-74	0.86
75-99	0.86

Enrollment Agreement / Payroll Deduction Authorization

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I have received an explanation regarding my options under Kaufman County benefit plans. I understand I have the option to have the Kaufman County redirect my salary (before-tax or after-tax) from my pay accordingly. I have indicated my benefit choices above and understand that I will be covered by these elections through the plan year, ending September 30, 2016. I acknowledge that my election is irrevocable unless there is a change in my family status (qualifying event). A change in family status includes: marriage, divorce, death of a spouse or dependent, birth or adoption of a child, or a change in your spouse's employment status. This does not apply to designation of a beneficiary which can be done at any time. I understand that I have 30 days to update my benefits after a change in family status. Kaufman County reserves the right to modify or discontinue any benefit program, or eligibility requirements for participation in any benefit program, at any time.

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

Employee Signature:_____ Date: _____