



Kent County Benefit Election Form

Part A

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

Employee Social Security No.	Employee Last Name	Employee First Name	M.I.	Sex	Birthdate	Work Phone
Home Address		City	State	Zip	Home Phone	

Date of Hire
Employee #
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Employee Coverage Elected Med Rx Den Vis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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 <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-1 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-2 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-3 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-4 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-5 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-6 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-7 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dep-8 Add <input type="checkbox"/> Delete <input type="checkbox"/>								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Medical Coverage Waive Coverage <input type="checkbox"/> Single Double Family BCBS Wellness Plan PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> BCN Wellness Plan HMO* <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <small>*BCN participants must choose a primary care physician on the separate BCN enrollment form.</small>	Prescription Coverage Waive Coverage <input type="checkbox"/> Single Double Family <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> OptumRx	Dental Coverage Waive Coverage <input type="checkbox"/> Single Double Family <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varipro	Vision Coverage Waive Coverage <input type="checkbox"/> Single Double Family <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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:** _____



**Kent County
Life Insurance
Beneficiary Form**

Part B

- 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		AGE	Rate per \$1,000
Insurance Benefit	\$ _____	<29057
Divide by 1,000	_____	30 - 34067
Times rate	_____	35 - 39076
Monthly Cost =	\$ _____	40 - 44114
		45 - 49209
		50 - 54371
		55 - 59646
		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%)

								Basic	Supplemental
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					
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: _____