

Employee Benefits Enrollment Form (19 Pay Periods 8/31/2022-5/31/2023)

2022-2023 Plan Year

Event/Employer Information						
Employee #:		Date of Hire:		Effective Date:		
Event: <input type="checkbox"/> New Hire <input type="checkbox"/> Family Status Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change				Work Status: <input type="checkbox"/> FMLA <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid		
Group Name: St. Johns County School District		Florida Blue Group #: 63316	Humana Group #: 673584		The Bailey Group Vision: V1	
Employee Information						
Social Security #:		Last Name:	First Name:		MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:	Apt #:	City:	State:	ZIP Code:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Home Phone: () ()	Cell Phone: () ()	Employee Type: <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Percentage	Email Address:			
Job Title:		Worksite Location:		Work Phone:		
Family with 2 SJCS District Employees Spouse Name:		Employee ID#:	Worksite Location:		Male Fw2 – Add Dependents Female Fw2 – No Dependents	
Basic Life Insurance						
Name of Beneficiary:		Relationship:		%:	Life Amount:	
Name of Contingent		Relationship:		%:		
Please place an "X" next to the desired elections for Medical, Dental, and Vision Coverage.						
In addition to select Pre- or Post-Tax for all deductions: <input type="checkbox"/> Pre-Tax* <input type="checkbox"/> Post-Tax						
Percentage Teachers Only Waive Coverage: <input type="checkbox"/> Indemnity <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision						
Medical <input type="checkbox"/> Indemnity	Plan 1 (5770) STANDARD			Plan 2 (3769) BUY UP		
	19-Pay Periods	EE Pro-Rate	ER Pro-Rate	19-Pay Periods	EE Pro-Rate	ER Pro-Rate
Employee Only	<input type="checkbox"/> \$ 63.84			<input type="checkbox"/> \$ 78.06		
Family with 2	<input type="checkbox"/> \$ 137.61 (\$68.80/\$68.81 EA)			<input type="checkbox"/> \$ 204.92 (\$102.46 EA)		
Family w/2 Single	<input type="checkbox"/> \$ 127.68 (\$63.84 EA)			<input type="checkbox"/> \$ 156.12 (\$78.06 EA)		
Family	<input type="checkbox"/> \$ 270.07			<input type="checkbox"/> \$ 337.94		
Dental	Dental Plan 1			Dental Plan 2		
	19-Pay Periods	EE Pro-Rate	ER Pro-Rate	19-Pay Periods	EE Pro-Rate	ER Pro-Rate
Employee Only	<input type="checkbox"/> \$ 0.00			<input type="checkbox"/> \$ 5.72		
Family with 2	<input type="checkbox"/> \$ 4.23 (\$2.11/\$2.12 EA)			<input type="checkbox"/> \$ 21.08 (\$10.54 EA)		
Family w/2 Single	<input type="checkbox"/> \$ 0.00			<input type="checkbox"/> \$ 11.44 (\$5.72 EA)		
Family	<input type="checkbox"/> \$ 20.02			<input type="checkbox"/> \$ 38.72		
Vision	Employee Only	Family with 2	Family w/2 Single	Family	EE Pro-Rate	ER Pro-Rate
	<input type="checkbox"/> \$ 0.00	<input type="checkbox"/> \$ 3.59 (\$1.79/\$1.80 EA)	<input type="checkbox"/> \$ 0.00	<input type="checkbox"/> \$ 7.53		

Continued on Other Side

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Please provide the required information for each dependent you are enrolling, continuing, or terminating Medical/Dental/Vision coverage. If enrolling new dependents, attach dependent eligibility documents (see list below).					Election (E, C, T) E = Enroll C = Continue T = Term		
Name (Last, First, MI)	Relation	Social Security #	Sex	Date of Birth	Medical	Dental	Vision
	Spouse						
	Child						
	Child						
	Child						
	Child						

In addition to these policies, do you or your dependents have other medical, dental, or vision coverage that will be in effect after these coverages begin? YES NO

If yes, complete:	Medical Carrier Name & Contract #:	Dental Carrier Name & Contract #:	Vision Carrier Name & Contract #:	Medicare Part A:	Medicare Part B:	Effective Date:
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Qualifying Events & Benefit Election Changes

As stated in the St. Johns County School District Employee Medical, Dental, and Vision Plans, I can only Add, Change, or Delete my medical, dental, or vision coverage during open enrollment, unless I experience a Family Status Change during the Plan year and meet and complete the following requirements:

1. Family Status change will be the loss of health coverage due to death of a spouse, termination of spouses' employment, divorce, or disability of a spouse. Other qualifying events are marriage, birth, dependent satisfies or ceases to satisfy requirements for coverage, adoption, or placement for adoption, etc.
2. Qualifying events must be reported to the Human Resources Benefits Department within 30 days from the date of the event. Any changes submitted after the 30-day time period will not be approved for coverage to employee's insurance.

Dependent Eligibility Documents

- **For Spouse:** A Certified copy of your Marriage Certificate **AND one of the following** *A copy of the front page of your 2021 federal tax return confirming this dependent is your spouse OR a document **dated within the last 60 days** such as a recurring monthly household bill. **The document must list your spouse's name, the date, and your mailing address.**
- **For Children up to age 26:** A copy of the child's birth certificate or adoption certificate naming you or your spouse as the child's parent. If you are covering a stepchild and your spouse is not a covered dependent, you must also provide documentation of your current relationship with your spouse as requested above.
- **For Children with Disabilities age 26 or older:** A copy of the child's birth certificate (or hospital birth record) AND Evidence of Social Security Disability (SSD) showing parent/guardian and dependent names.

2022 & 2023 HEALTH RISK ASSESSMENT PROGRAM – For complete program details, go to “Benefits Bulletin Board” located at your worksite, sjcsd.mbaileysgroup.com, New Hire Benefits-at-a-Glance Booklet, and 2023 Open Enrollment Benefits-at-a-Glance booklet.

- Employees hired **after April 1, 2022 and before March 25, 2023**, and born in an **EVEN** year **ARE NOT** required to complete these steps by November 15, 2022. **Employees and their spouse will be required to complete these steps January 1, 2024, through November 15, 2024.**
- Employees hired **after April 1, 2022 and before March 25, 2023**, and born in an **ODD** year **ARE NOT** required to complete these steps in 2022. **Employees and their spouses are required to complete these steps January 1, 2023 through November 15, 2023.**

Spousal Surcharge \$35 for 19 Pay Periods YES NO

***Compensation Reduction Agreement**

With this authorization, on the appropriate benefit enrollment form(s), I have enrolled for coverage under the St. Johns County School Board Employee Benefit Plan. I do elect to have insurance premiums deducted from my compensation for the Employee Benefit Plan coverage under the Section 125 Plans. I do understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease. Prior to each Plan Year, I will be offered the opportunity to change my benefit election for the following Plan Year. *Open Enrollment changes do not require a new completed enrollment form.*

X _____ Date: _____
Signature or legal representative signature