St. Johns County School District

Family Status Change Election Form
Medical Dental Vision

Employee Name: _____

Employee ID #:_____ Effective: _____

I understand that any change to my benefit election must be both necessitated by and consistent with a qualifying life event and must comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

All required forms, supporting documentation, and updates through BusinessPlus (SunGard) Employee Online must be completed and submitted within **30 days** of the Qualifying Life Event. Supporting documentation must be provided at the time of submission.

Insurance changes will take effect on the date of the qualifying event.

I certify that I have incurred the following change in my family status:

- ☐ Marriage (Marriage Certificate with Seal)
- ☐ Divorce (Final Divorce Decree: First and last page containing the judge's signature)
- ☐ Birth, adoption, or placement for adoption of a child (Birth Certificate with parents' names or court adoption paperwork)
- ☐ Death of my spouse and/or dependent (Certified Death Certificate)
- ☐ Termination or commencement of employment by my spouse (Employer statement with effective insurance date or insurance termination date)
- ☐ Change of employment status (e.g., part-time to full-time or vice versa) for myself or my spouse (Employer documentation required)
- ☐ Dependent satisfies or ceases to satisfy eligibility requirements for coverage (e.g., Medicaid or Florida Healthy Kids with qualifying date)
- ☐ Other (please briefly explain your Qualifying Life Event below):

_____

_____

If you are enrolling any dependents onto your insurance plan, you must provide dependent eligibility documents. Please refer to page 2 of the Employee Benefits Enrollment Form.

Employee Signature: _____ Date: _____

Please return this signed election form, Employee Benefits Enrollment Form, and required dependent documentation noted above to the St. Johns County School District, Human Resources Department, Attention: Sheryl Mclean (904) 547-7610.

Employee Benefits Enrollment Form (19 Pay Periods 8/31/2025-5/31/2026)
2025-2026 Plan Year

Event/Employer Information

Employee #:	Date of Hire:	Effective Date:

Event:
☐ New Hire ☐ Family Status Change ☐ Beneficiary Change
☐ Termination ☐ Open Enrollment ☐ Address Change ☐ Name Change

Work Status:
☐ FMLA ☐ Leave of Absence
☐ Paid ☐ Unpaid

Employee Information

Social Security #:	Last Name:	First Name:	MI:	Sex: ☐M ☐F	Date of Birth:

Street Address: **Apt #:** **City:** **State:** **ZIP Code:**

Marital Status:
☐ Single ☐ Married
☐ Divorced
☐ Widowed

Home Phone: ( )	Cell Phone: ( )	Employee Type: ☐Salary ☐Hourly ☐Percentage	Email Address:

Job Title: **Worksite Location:** **Work Phone:**

Family with 2 SJCSD 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, select Pre- or Post-Tax for all deductions: ☐ Pre-Tax* ☐ Post-Tax

Percentage Teachers Only Waive Coverage: ☐ Indemnity ☐ Medical ☐ Dental ☐ Vision

Medical ☐ 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	☐ $ 68.16			☐ $ 83.45		
Family with 2	☐ $ 154.74 ($77.37 EA)			☐ $ 227.14 ($113.57 EA)		
Family w/2 Single	☐ $ 136.32 ($68.16 EA)			☐ $ 166.90 ($83.45 EA)		
Family	☐ $ 287.20			☐ $ 360.19		

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	☐ $ 0.00			☐ $ 6.15		
Family with 2	☐ $ 5.08 ($2.54 EA)			☐ $ 23.20 ($11.60 EA)		
Family w/2 Single	☐ $ 0.00			☐ $ 12.30 ($6.15 EA)		
Family	☐ $ 21.47			☐ $ 41.59		

Vision	Employee Only	Family with 2	Family w/2 Single	Family	*EE Pro-Rate*	*ER Pro-Rate*
	☐ $ 0.00	☐ $ 3.88 ($1.94 EA)	☐ $ 0.00	☐ $ 7.82		

For Administrative Use:

STD ☐Opt 1 ☐Opt 2 ☐Opt 3 **LTD** ☐Basic ☐Buy-Up **Med 125**_____ **Dep 125**_____	**Add'l Term Life:** **EE** _____ **SP** _____ **CH**_____	**Spouse:** Missing_____ ☐Affidavit $0.00 or $35.00 ☐Marriage License ☐Bill/Income Tax Form	**Children:** ☐Birth Certificates – Have all? Missing: _____ _____

Continued on Other Side

Employee Benefits Enrollment Form (19 Pay Periods 8/31/2025-5/31/2026)
2025-2026 Plan Year

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						

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 the death of a spouse, termination of spouse's employment, divorce, or disability of a spouse. Other qualifying events are marriage, birth, dependent satisfies or ceases to meet 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 event date. Any changes submitted after the 30 days will not be approved for employee insurance coverage.

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 2023 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 name, your spouse's name, date, and mailing address.**
- **For Children up to age 26:** A certified copy of the child's birth 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.

2025 & 2026 HEALTH RISK ASSESSMENT PROGRAM
For complete program details, go to the "Benefits Bulletin Board" located at your worksite, sjcsd.mbaileygroup.com, the New Hire Benefits-at-a-Glance Booklet, and the 2025 Open Enrollment Benefits-at-a-Glance booklet.

Employees hired **after June 1, 2025**, must follow the steps outlined below based on their birth year:

- **Born in an EVEN year**: No action is required in **2025**. Employees and their spouses must complete these steps between **January 1, 2026**, and **November 15, 2026**.
- **Born in an ODD year**: No action is required in **2025**. Employees and their spouses must complete these steps between **January 1, 2027**, and **November 15, 2027**.

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 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. Before 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.* I understand it is my responsibility to review my paycheck stub for accuracy and to report any discrepancies to the Benefits Department as soon as possible.

X_____Date: _____
Signature or legal representative signature

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 30 – May 30
(Please Print)

Is your address different from your Spouse's? (Please check one) ☐ No ☐ Yes

If yes, what is your spouse's address? _____
(Street)

_____
(City, State, and Zip Code)

A. Who must complete this form?

If you are a full-time St. Johns County School District employee who is married (as defined by Florida Law) and elects St. Johns County School District medical coverage for your spouse/family, you **must** complete section B of this form.

Insurance Fraud Warning: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraudulent act against a benefit plan, submits an application or a claim containing a false or deceptive statement is guilty of insurance fraud.

B. Please place a check next to the applicable statement:

My spouse is:

_____ employed full-time/eligible for employer-sponsored medical insurance
Employer Name _____

_____ employed full-time/not eligible for employer-sponsored medical insurance
Employer Name _____

_____ employed full-time/employer does not offer medical insurance
Employer Name _____

_____ Self-employed

_____ employed part-time/employer does not offer employer-sponsored medical insurance to part-time employees
Employer Name _____

_____ Disabled

_____ Unemployed

_____ employed by St. Johns County School District

_____ retired

If your spouse is eligible for medical insurance offered through their employer, your spouse is eligible for coverage under the St. Johns County School District Self-Funded Medical Plan only with the addition of a monetary surcharge.

I hereby certify that the information provided above is correct. I further understand that I must report any changes in my spouse's employment status and/or changes in my spouse's eligibility for employer-sponsored medical insurance to St. Johns County School District's Human Resources Department. **Failure to accurately report a spouse's employment status or changes in the spouse's eligibility for employer-sponsored insurance may result in your spouse's coverage being terminated and may be grounds for disciplinary action against you up to and including termination of employment.**

Employee Signature _____ Date _____

PLEASE RETURN YOUR COMPLETED FORM TO THE HUMAN RESOURCE BENEFITS DEPARTMENT. *Failure to return this document by the due date will result in the implementation of the spousal surcharge until such time as a form is received. At that time, the surcharge may be stopped however, refunds for any surcharge collected will not be granted.*