

Reset Form

2020 ENROLLMENT/CHANGE SHORT FORM

Broward County, Division of Human Resources, Employee Benefit Services, shall collect your Social Security Number as allowed under section 119.071(5)(a)2, Florida Statutes, for the following purpose: to match, verify, and retrieve benefit plan information as well as for the purpose of payment and audit of premiums collected. You are being provided notice of this activity pursuant to section 119.071(5)3, Florida Statutes.

1 EMPLOYEE'S PERSONAL INFORMATION			
COUNTY ID NUMBER	LAST NAME	FIRST NAME	INITIAL
TELEPHONE (PERSONAL)	EMAIL (PERSONAL)	TELEPHONE (WORK)	DIVISION

2 I want to:		<input type="checkbox"/> ENROLL	<input type="checkbox"/> CHANGE	<input type="checkbox"/> CANCEL
<input type="checkbox"/> Spousal Surcharge	<i>If cancel, must provide proof that no longer eligible for other coverage</i>			
<input type="checkbox"/> Legal Insurance (LE1)	<i>May enroll next open enrollment</i>			
<input type="checkbox"/> Long Term Disability (LT1)	<input type="checkbox"/> Premium Waiver Approved	<i>Need medical underwriting form to enroll</i>		
<input type="checkbox"/> Flexible Spending Account (Medical) \$ _____	<input type="checkbox"/> Flexible Spending Account (Dependent Care) \$ _____	<i>Need medical underwriting form to enroll or increase coverage</i>		
<input type="checkbox"/> Life Insurance-Additional coverage (LI3)	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$175,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$225,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$275,000 <input type="checkbox"/> \$300,000			
<input type="checkbox"/> Life-Optional Spouse/DP (LI4)	\$12,500 Spouse/DP \$1.44	<i>May enroll if a new spouse/Domestic Partner and enrolled in additional life</i>		
<input type="checkbox"/> Life-Optional Child (LI5)	\$12,500 Child(ren) \$1.15 (covered thru age 26)	<i>May enroll if a Newborn, new Adoption, or Guardianship</i>		
<input type="checkbox"/> Personal Income Protection Plans- AllState		<input type="checkbox"/> Accident	<input type="checkbox"/> Cancer	<input type="checkbox"/> Critical Illness
		<input type="checkbox"/> Cancer	<input type="checkbox"/> Hospital	<i>Enroll during next open enrollment</i>

3 Additional documentation required. Contact Employee Benefits to confirm correct documentation						
I want to:		<input type="checkbox"/> ADD	<input type="checkbox"/> CANCEL			
a	MY COVERAGE	<input type="checkbox"/> MEDICAL	<input type="checkbox"/> DENTAL	<input type="checkbox"/> VISION	QUALIFYING EVENT <i>(Reason for change)</i>	
<i>Plan Choice</i> →						
b	MY DEPENDENTS' COVERAGE	<input type="checkbox"/> MEDICAL	<input type="checkbox"/> DENTAL	<input type="checkbox"/> VISION		
RELATIONSHIP CODE:		3. Child	4. Child of Domestic Partner	5. Guardian of	6. Domestic Partner	7. Grandchild
DEPENDENT(S) NAME	Relationship Code ↓	SOCIAL SECURITY NUMBER	BIRTHDATE	Child born prior to 12/31/1993 S Student F Financially Dependent D Disabled	MALE/ FEMALE <input type="checkbox"/> M <input type="checkbox"/> F	QUALIFYING EVENT <i>(Reason for change)</i>
SPOUSE/DOMESTIC PARTNER NAME	<input type="checkbox"/> Spouse <input type="checkbox"/> DomP				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD NAME	Check 3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD NAME	3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD NAME	3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	

EMPLOYEE'S STATEMENT AND AUTHORIZATION

I acknowledge that I have provided true and official documentation, and that the dependent(s) enrolled meet the eligibility criteria, as specified by Broward County. If a post audit of the dependent(s) enrolled shows that he/she does not meet the eligibility requirements of the plan, I understand that I will be held legally and financially responsible for the repayment of all benefit claims incurred by any of my ineligible Dependents. Florida Statute 817.234 clearly states that any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Any person committing such fraud will be subject to appropriate action by Broward County and/or the insurance carrier.

Sign below to authorize payroll deduction for coverage(s) selected and to acknowledge that, under Section 125, pre-taxed deductions cannot be revoked or changed unless a qualifying event occurs, and the change is consistent with the qualifying event. Pre-taxed coverage(s) remain in effect until a new authorization to start, change, or cancel coverage/s, subject to contract provisions, Section 125, and County policies is submitted and processed by Employee Benefit Services.

Employee's Signature _____ Date _____

EBS USE ONLY:		<input type="checkbox"/> CH <input type="checkbox"/> QE	BENEFITS REP	EFFECTIVE DATE
KEYED BY	AUDITED BY	<input type="checkbox"/> PREMIUM WAIVER	<input type="checkbox"/> FELONIOUS ASSAULT- FA1 (Bus Drivers) <input type="checkbox"/> HAZARDOUS OCC- HO1 – (Security Guards/Park Rangers)	
KEYED DATE	AUDITED DATE			

2020 BI-WEEKLY PAYROLL DEDUCTIONS

TIER OF COVERAGE	HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION GUIDELINES			
	County Funded	Employee Contribution Under age 55 (pretax)	Total 2020 Contribution allowed by IRS	Catch-up Contribution
Employee Only	\$1,200	\$2,350	\$3,550	\$1,000
Employee + Spouse	\$2,400	\$4,700	\$7,100	\$1,000 per member age 55 and over *
Employee + Children				
Employee + Family				
<i>HSA amounts shown are based on enrollment for 12 months. Amounts will be prorated based on when your benefits start.</i>		<i>*Catch-up contributions are made in addition to any regular HSA contributions. Maximum Catch-up contribution for 2020 is \$1,000. You are eligible to make catch-up contributions if you meet the eligibility requirements for regular contributions and have attained age 55 by the end of your taxable year.</i>		

EMPLOYEE OPTIONAL LIFE INSURANCE BIWEEKLY DEDUCTIONS (Effective 01/01/2020) Standard Insurance Company

Coverage/Age	Under 30	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 -69	70 & over
\$25,000	\$1.04	\$1.36	\$1.49	\$1.62	\$2.25	\$3.27	\$5.80	\$8.88	\$15.57	\$24.12
\$50,000	\$2.08	\$2.72	\$2.98	\$3.23	\$4.50	\$6.53	\$11.61	\$17.77	\$31.13	\$48.23
\$75,000	\$3.12	\$4.08	\$4.47	\$4.85	\$6.75	\$9.80	\$17.41	\$26.65	\$46.70	\$72.35
\$100,000	\$4.15	\$5.45	\$5.95	\$6.46	\$9.00	\$13.06	\$23.22	\$35.54	\$62.26	\$96.46
\$125,000	\$5.19	\$6.81	\$7.44	\$8.08	\$11.25	\$16.33	\$29.02	\$44.42	\$77.83	\$120.58
\$150,000	\$6.23	\$8.17	\$8.93	\$9.69	\$13.50	\$19.59	\$34.82	\$53.31	\$93.39	\$144.69
\$175,000	\$7.27	\$9.53	\$10.42	\$11.31	\$15.75	\$22.86	\$40.63	\$62.19	\$108.96	\$168.81
\$200,000	\$8.31	\$10.89	\$11.91	\$12.92	\$18.00	\$26.12	\$46.43	\$71.08	\$124.52	\$192.92
\$225,000	\$9.35	\$12.25	\$13.40	\$14.54	\$20.25	\$29.39	\$52.23	\$79.96	\$140.09	\$217.04
\$250,000	\$10.38	\$13.62	\$14.88	\$16.15	\$22.50	\$32.65	\$58.04	\$88.85	\$155.65	\$241.15
\$275,000	\$11.42	\$14.98	\$16.37	\$17.77	\$24.75	\$35.92	\$63.84	\$97.73	\$171.22	\$265.27
\$300,000	\$12.46	\$16.34	\$17.86	\$19.38	\$27.00	\$39.18	\$69.65	\$106.62	\$186.78	\$289.38

FSA MEDICAL Min \$260 annually; Max \$2,750 annually

FSA DEPENDENT CARE - Min \$260 annually; Max \$5,000 annually

SPOUSE/DP & DEPENDENT LIFE INSURANCE (DOES NOT INCLUDE AD&D INSURANCE)

Bi-weekly rates are after-tax and are a fixed amount. Employee must purchase a minimum of \$25,000 Life & AD&D insurance on themselves. Coverage for Spouse/DP - \$12,500 Premium \$1.44. Coverage for Child Dependent(s) - \$12,500 per child. Premium \$1.15 Child is covered through end of year in which they turn 26.

LONG TERM DISABILITY – Standard Insurance Company - LTD RATES EFFECTIVE 04/01/2014

Bi-weekly premium amounts for selected projected annual earnings levels are shown below for use in estimating cost. Premiums are automatically adjusted during the year for changes to pay rate and age that moves someone to a new premium bracket.

Earnings	To Age 40	40-49	50-59	60-64	65 & Over
15,000	\$1.27	\$2.31	\$4.62	\$6.43	\$7.75
20,000	\$1.69	\$3.08	\$6.15	\$8.58	\$10.33
25,000	\$2.12	\$3.85	\$7.69	\$10.72	\$12.91
30,000	\$2.54	\$4.62	\$9.23	\$12.87	\$15.50
35,000	\$2.96	\$5.38	\$10.77	\$15.01	\$18.08
40,000	\$3.38	\$6.15	\$12.31	\$17.15	\$20.66
45,000	\$3.81	\$6.92	\$13.85	\$19.30	\$23.24
50,000	\$4.23	\$7.69	\$15.38	\$21.44	\$25.83
55,000	\$4.65	\$8.46	\$16.92	\$23.59	\$28.41
60,000	\$5.08	\$9.23	\$18.46	\$25.73	\$30.99
65,000	\$5.50	\$10.00	\$20.00	\$27.88	\$33.58
70,000	\$5.92	\$10.77	\$21.54	\$30.02	\$36.16
75,000	\$6.35	\$11.54	\$23.08	\$32.16	\$38.74
80,000	\$6.77	\$12.31	\$24.62	\$34.31	\$41.32
85,000	\$7.19	\$13.08	\$26.15	\$36.45	\$43.91
90,000	\$7.62	\$13.85	\$27.69	\$38.60	\$46.49
95,000	\$8.04	\$14.62	\$29.23	\$40.74	\$49.07
100,000	\$8.46	\$15.38	\$30.77	\$42.88	\$51.65
105,000	\$8.88	\$16.15	\$32.31	\$45.03	\$54.24
110,000	\$9.31	\$16.92	\$33.85	\$47.17	\$56.82
115,000	\$9.73	\$17.69	\$35.38	\$49.32	\$59.40
120,000	\$10.15	\$18.46	\$36.92	\$51.46	\$61.98