New Hire **Benefits Statement** of **Acknowledgement, Understanding & Commitment**

By participating in a Broward County benefit program, you hereby acknowledge and accept the conditions set forth in the following Employee Statement:

1. I authorize and request payroll deduction(s) for the benefits I have selected.
2. I agree to provide documentation, as required by Broward County, evidencing dependent status, domestic partner status or student/financial status for any person covered under a Broward County insurance plan within 31 days of a request for such documentation. If my dependent does not meet the eligibility requirements of the plan or I fail to supply any requested documentation, I understand that this may cause the ineligible dependent to be removed from coverage retroactive to the enrollment date, and I will be held legally and financially responsible for the repayment of all premiums, subsidies, and benefit claims incurred or paid on behalf of my ineligible dependent.
3. I understand that health, dental and vision insurance premiums and Flexible Spending Account contributions will be pre-taxed to the extent possible and that my income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may slightly affect my Social Security benefits in the future. If insuring an Over Age Dependent between the ages 26 and 30, or a Domestic Partner or child/children of a Domestic Partner, a portion of my premium attributable to their coverage will be deducted on an after-tax basis and I will pay imputed income on the portion of the Broward County subsidy provided to offset the cost of the health plan.
4. I acknowledge that I cannot stop or change benefits paid for on a pre-tax basis during the plan year unless I experience a relevant qualifying event.
5. I understand that a Section 125 Flexible Spending Account (Health Care and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan, and that any amount remaining in either spending account that is not used during the plan year will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which I am reimbursed cannot be claimed on my income tax return. As Over Age Dependent children ages 26 to 30 and domestic partners or children of a domestic partner do not meet the IRS definition of dependent, their coverage is not eligible for pre-tax consideration or reimbursement through either type of Section 125 Flexible Spending Account, Health Reimbursement Account under a Consumer Driven Health plan or Health Savings Account under a High Deductible Health Plan.
6. I understand and agree that Broward County and the third party FSA/HRA/HSA administrator will not incur any liability resulting from my failure to read all rules pertaining to benefit enrollment or to sign or accurately complete the Enrollment/Change Form. I also understand that elections for benefits on a pretax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a relevant qualifying event.
7. I agree for myself and covered members of my family and other dependents under County insurance plans to be bound by the benefits, deductibles, coinsurance, copayments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which I enrolled.

Continued on Reverse Side

8. I understand that Broward County, Division of Human Resources, Employee Benefit Services Section, will collect my 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. I am being provided notice of this activity pursuant to section 119.071(5)3, Florida Statutes.

9. I understand that a Mandatory Insurer Reporting Law (Section 111 of Public Law 110173) requires group health plan insurers, third party administrators and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the secretary of the Department of Health and Human Services, information that the secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers' compensation laws or plans. Two key elements that will be required to be reported are SSNs (or HICNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable.

10. I certify that the information I supplied on the online enrollment system or Benefit Enrollment/Change Form and other benefit documents is true and complete to the best of my knowledge.

I understand 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 under section 817.234, Florida Statutes. Any person committing such acts will be subject to disciplinary action by Broward County and/or any other appropriate action.

I acknowledge and accept the Employee Statement.

Print Name ______________________________ **Signature** ______________________________

Email ______________________________ **ID#** ______________________________

Division ______________________________ **Date** ______________________________

Cell ______________________________ **Work #** ______________________________

Submit