2025 Benefits Application for Qualifying Life Event

Any employee who knowingly and with intent to harm, defraud or deceive any insurer, or files a statement of claim/application containing any false, incomplete, or misleading information is subject to corrective action and/or termination.

Employee Information:	Name:			Email:
Employee #:	Start Date:	☐ Full-time ☐ Part-time	☐ Smoker ☐ Non-Smoker	Mobile #:

Select one choice for each of the following plans: Visit: https://employee.browardhealth.org/pages/employee-benefits for detailed benefit information.

MEDICAL PLAN	Coverage Type:	DENTAL PLAN	Coverage Type:	VISION PLAN (choose one)
☐ Aetna **Best Choice** EPO	☐ Employee Only	☐ Aetna DMO	☐ Employee Only	☐ Employee Only
☐ Aetna Select Access EPO	☐ Employee & Spouse	☐ Reliance PPO	☐ Employee & Spouse	☐ Employee & Spouse
☐ Aetna POS II HDHP	☐ Employee & Child/ren		☐ Employee & Child/ren	☐ Employee & Child/ren
	☐ Family		☐ Family	☐ Family
	☐ Waive Coverage		☐ Waive Coverage	☐ Waive Coverage

Select Reason for Application: You must submit documentation to support eligibility for all dependents: *i.e.: marriage, birth certificates, social security cards*. All documentation must be submitted within 30 days of qualifying life event. *Other than newborn enrollments*, the effective start date of eligibility will be the first of the month following the date of event.

☐ Birth of Child – copy of birth certificate and child's SSN required	Effective Date of Birth (DOB):
☐ Marriage – copy of marriage certificate and spouse's SSN required	Effective Date of Marriage:
☐ Change of Status: ☐ Full-time to Part-time ☐Part-time to Full-time	Effective Date of Status Change:
☐ Divorce/Legal Separation – copy of court-ordered decree required	Effective Date of Divorce/Legal Separation:
☐ Loss or Gain of Coverage – copy of benefits termination letter required	Effective Date of of Loss/New Coverage:
☐ Addition/Deletion of Dependent(s) – supportive documentation required	Effective Date of Event:
☐ Other (please write in):	Effective Date of Event:

Eligible Dependents to be covered and Tobacco Attestation: Broward Health has established different contribution rates for employees and spouses who use tobacco products and those who do not.

	Name (first name/last name)	Social Security #	Date of Birth	Gender	Smoker?
Spouse					☐ Yes ☐ No
Child					
Child					
Child					

Voluntary Plans: * Employees can cancel *these voluntary plans* (administered thru RELIANCE STANDARD LIFE) at any time with written request submitted to Benefits@browardhealth.org. **FSA and DSA benefits** (administered through WAGEWORKS) **cannot** be terminated in a plan year unless you experience a Qualifying Event.

* **Short Term Disability** (for employee only)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Note:** Disability Insurance is subject to pre-existing condition limitations and additional benefit provisions.
* **Long Term Disability** (for employee only)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	
* **Supplemental Life Insurance:** *(Employee or Spouse enrollment is required in order to enroll for Child/ren coverage.)* - **EOI** (Evidence of Insurability) is required for coverage amounts **over $500k** for Employee and **over $50K** for Spouse.	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only **Coverage Amount:** $_____ ☐ **EE & Spouse** **Coverage Amount:** $_____ **Spouse Amount:** $_____ ☐ EE & Child/ren **Coverage Amount:** $_____ ☐ **Family** **Coverage Amount:** $_____ **Spouse Amount:** $_____
* **Critical Care Insurance:** *(For Spouse benefit, coverage amount selected cannot exceed 100% of total amount covered by employee – Child coverage is 50% of employee's coverage amount.)*	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only **Coverage Amount:** $_____ ☐ **EE & Spouse** **Coverage Amount:** $_____ **Spouse Amount:** $_____ ☐ EE & Child/ren **Coverage Amount:** $_____ ☐ **Family** **Coverage Amount:** $_____ **Spouse Amount:** $_____
* **Hospital Indemnity**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only ☐ EE & Spouse ☐ EE & Child ☐ Family
* **Accident Insurance**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only ☐ EE & Spouse ☐ EE & Child ☐ Family
* **Legal Insurance** (Metlife Legal Plans)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	
* **Health Savings Account** (for HDHP only)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	Annual Pledge: $_____
FSA – Healthcare (WageWorks)**:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	Annual Pledge: $_____
FSA - Dependent Care (WageWorks)**:**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	Annual Pledge: $_____

I authorize Broward Health to process the above benefit elections and deduct my benefit contributions from my earnings. I understand that my coverage is dependent upon payment of amounts required and to remain in an eligible status. I also understand that failure to submit all required supportive documentation or enrollment applications will be deemed as waiver of benefit for employee and/or dependents.

Employee Print Name: _____ **Employee Signature:** _____ **Date:** _____