2027 Benefits Application for Qualifying Life Event

Visit: https://employee.browardhealth.org/pages/employee-benefits for detailed benefit information. **NOTE: 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 #:

MEDICAL PLAN (choose one)	**Coverage** (choose one)	**DENTAL PLAN** (choose one)	**Coverage** (choose one)	**VISION PLAN** (choose one)
☐ Aetna **Best Choice** EPO	☐ Employee Only	☐ Aetna DMO	☐ Employee Only	☐ Employee Only
☐ Aetna Open Select EPO	☐ Employee & Spouse	☐ Aetna 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 or new coverage 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**): *ie: Open Enrollment, etc.* _____	Effective Date of Event:

Eligible Dependents to be covered and Tobacco Attestation: Broward ealth 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 voluntary plans at any time with written request submitted to Benefits@browardhealth.org. FSA and DSA benefits CANNOT** be terminated in a plan year unless you experience a **Qualifying Event**. For questions, contact the Corporate Benefits Department at 954.473.7254 or 7373.

*** Short Term Disability (VOYA - STD-EE only)**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Vendor: VOYA Financial** – STD is NOT subject to pre-existing condition limitations. **LTD will be subject to Evidence of Insurability** (EOI)
*** Long Term Disability (VOYA – LTD - EE only)**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	
*** Accident Insurance (VOYA)**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only ☐ EE & Spouse ☐ EE & Child ☐ Family
*** Critical Care Insurance - (VOYA - select a coverage amount ranging from $5,000 to $40,000):** *(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 (VOYA)**	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	☐ EE Only ☐ EE & Spouse ☐ EE & Child ☐ Family
*** Supplemental Life Insurance (VOYA):** (Employee or Spouse enrollment is required in order to enroll for Child coverage.) ***See Benefits Guide for new plan changes in Year 2027 regaring Evidence of Insurability (EOI)***	☐ **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:** $_____
*** 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.	**Monthly EE Contribution:** $_____
FSA – Health: (for Employees & Dependents)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Annual Pledge:** $_____ (Health Equity/Wageworks)
FSA - Dependent Care - (for daycare & elder Care expenses only)	☐ **Yes**, I want to elect.	☐ **No**, I am waiving coverage.	**Annual Pledge:** $_____ (Health Equity/Wageworks)

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 for dependents will be deemed as waiver of benefit for employee's dependents.

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