BENEFITS ENROLLMENT & CHANGE FORM

Updated: 4/2022

CHECK ONLY ONE ...	
NEW EMPLOYEE ENROLLMENT	☐
QUALIFYING LIFE EVENT CHANGE	☐

IREDELL COUNTY NC

FOR HR USE ONLY ...	
HIRE DATE:	_____
EFFECTIVE DATE:	_____
PREMIUM START DATE:	_____

EMPLOYEE INFORMATION ... PLEASE PRINT CLEARLY

EMPLOYEE #:	NAME (FIRST NAME, MI, LAST NAME):	
ADDRESS:		
SS#:	ANNUAL SALARY:	DATE OF BIRTH:

GENDER: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE

BLUECROSS BLUESHIELD MEDICAL - LINCOLN DENTAL - COMMUNITY EYE CARE VISION BENEFITS (PAGES 4 - 22 IN THE BENEFITS BOOK) ...

TYPE OF COVERAGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD	EMPLOYEE + CHILDREN	EMPLOYEE + FAMILY	OPT OUT
MEDICAL	☐ PPO BASE ☐ HDHP/ with HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HDHP/ with HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HDHP/with HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HDHP/ with HSA ☐ PPO BUY-UP	☐ PPO BASE ☐ HDHP/ with HSA ☐ PPO BUY-UP	☐ WITH $2,000 HEALTH REIMBURSEMENT ACCOUNT ☐ WITHOUT HEALTH REIMBURSEMENT ACCOUNT **You must provide proof of other coverage to elect this plan**
DENTAL	☐ LOW PLAN ☐ HIGH PLAN	☐ LOW PLAN ☐ HIGH PLAN		☐ LOW PLAN ☐ HIGH PLAN	☐ LOW PLAN ☐ HIGH PLAN	☐ Initial in this box to WAIVE Dental Coverage
VISION	☐ COMPREHENSIVE ☐ EYEWEAR	☐ COMPREHENSIVE ☐ EYEWEAR		☐ COMPREHENSIVE ☐ EYEWEAR	☐ COMPREHENSIVE ☐ EYEWEAR	☐ Initial in this box to WAIVE Vision Coverage

COMPLETE THIS SECTION FOR ANY CHILD(REN) OR FAMILY WISH TO COVER ON YOUR MEDICAL, DENTAL, AND/OR VISION PLANS ...

COVERED DEPENDENTS	FIRST NAME MIDDLE INITIAL LAST NAME	SOCIAL SECURITY # *XXX-XX-XXXX*	DATE OF BIRTH *XX/XX/XXXX*	GENDER *MALE / FEMALE*	MUST WRITE "ADD" OR "DROP" MEDICAL	DENTAL	VISION
SPOUSE:							
CHILD:							
CHILD:							
CHILD:							
CHILD:							

*** PLEASE LIST ADDITIONAL CHILD(REN) ON A SEPARATE SHEET OF PAPER "IF" NEEDED ***

HEALTH SAVINGS ACCOUNT (HSA):
Only available with the HDHP
$3,650 individual / $7,300 Family
Includes County Contribution

PAY PERIOD ELECTION: $ _____
ANNUAL ELECTION: $ _____
(PAY PERIOD ELECTIONS X'S 24 PAY PERIODS)

☐ NEW ENROLLMENT IN THE HSA PLAN
☐ CHANGE MY PERSONAL HSA CONTRIBUTION
☐ CANCEL MY PERSONAL HSA CONTRIBUTION

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA):
$2,750 maximum contribution

PAY PERIOD ELECTION: $ _____
ANNUAL ELECTION: $ _____ (PAY PERIOD ELECTIONS X'S 24 PAY PERIODS)

DEPENDENT CARE (FSA):
$5,000 maximum contribution

PAY PERIOD ELECTION: $ _____
ANNUAL ELECTION: $ _____ (PAY PERIOD ELECTIONS X'S 24 PAY PERIODS)

LINCOLN SUPPLEMENTAL BENEFITS (PAGES 29 - 40 IN THE BENEFITS BOOK) ...

TYPE OF COVERAGE	ENROLLMENT SECTION	AMOUNT OF COVERAGE	BI-WEEKLY DEDUCTION (FOR 24 PAY PERIODS)
SHORT-TERM DISABILITY EMPLOYEE ONLY maximum of $500 per week, not to exceed 70% of salary duration of 13 weeks.	☐ YES ☐ NO	**WEEKLY BENEFIT AMOUNT** ☐ $200 ☐ $250 ☐ $300 ☐ $350 ☐ OTHER: $ _____	$8.63 $10.79 $12.95 $15.10 OTHER: $ _____
LONG-TERM DISABILITY EMPLOYEE ONLY maximum of $2000 per month, not to exceed 60% of monthly salary in $500 increments.	☐ YES ☐ NO	**MONTHLY BENEFIT AMOUNT** ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000	$3.20 $6.40 $9.60 $12.80
DEPENDENT TERM LIFE	☐ YES ☐ NO	☐ Spouse ☐ Children # _____	$0.89 $10,000 - SPOUSE & CHILD(REN) AGES 6 MTHS TO 26 $100 FOR CHILD(REN) 14 DAYS TO 6 MTHS
VOLUNTARY EMPLOYEE LIFE (GI $200,000)	☐ YES ☐ NO	$ _____	$ _____

****** Voluntary Employee Life MUST be elected to enroll in Voluntary Spouse, Child and AD&D coverages. Spouse coverage cannot exceed 100% of Employee Coverage for Voluntary Basic Life or AD&D coverages******

VOLUNTARY SPOUSE LIFE (GI $30,000)	☐ YES ☐ NO	$ _____	$ _____
VOLUNTARY CHILD LIFE	☐ YES ☐ NO	☐ $5,000 # _____ ☐ $10,000 # _____	$0.60 $1.20
VOLUNTARY AD&D *** Spouse is eligible for up to 100% of the Employee amount of coverage. ***	☐ YES ☐ NO	**EMPLOYEE** ☐ $25,000 $0.29 ☐ $50,000 $0.58 ☐ $100,000 $1.15 ☐ $150,000 $1.73 ☐ OTHER: $ _____	**SPOUSE** ☐ $25,000 $0.29 ☐ $50,000 $0.58 ☐ $100,000 $1.15 ☐ $150,000 $1.73 ☐ OTHER: $ _____
			Child(ren) ☐ $5,000 $.09 ☐ $10,000 $0.18

OTHER SUPPLEMENTAL BENEFITS (PAGES 23 - 26 AND PAGE 41)

TYPE OF COVERAGE	ENROLLMENT SECTION	AMOUNT OF COVERAGE	BI-WEEKLY DEDUCTION (FOR 24 PAY PERIODS)
TRANSAMERICA WHOLE LIFE	☐ YES ☐ NO	$ _____	$ _____
		SPOUSE: $ _____ CHILD 1: $ _____ CHILD 2: $ _____ GRANDCHILD 3: $ _____	SPOUSE: $ _____ CHILD 1: $ _____ CHILD 2: $ _____ GRANDCHILD 3: $ _____
TRANSAMERICA CRITICAL ILLNESS	☐ YES ☐ NO	$ _____	$ _____
TRANSAMERICA CANCER	☐ YES ☐ NO	☐ **PLAN 1:** *($3,000 INITIAL DIAGNOSIS)*	☐ EMPLOYEE ONLY $10.31 ☐ EMPLOYEE + CHILD(REN) $11.86 ☐ EMPLOYEE + FAMILY $18.86
		☐ PLAN 2: *($10,000 INITIAL DIAGNOSIS)*	☐ EMPLOYEE ONLY $19.61 ☐ EMPLOYEE + CHILD(REN) $22.09 ☐ EMPLOYEE + FAMILY $35.13

FOR TRANSAMERICA BENEFITS: HAVE YOU USED TOBACCO PRODUCTS DURING THE PREVIOUS TWELVE (12) MONTHS (CIRCLE ANSWER)? YES / NO

ALLSTATE ACCIDENT	☐ YES ☐ NO	☐ EMPLOYEE ONLY ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + FAMILY	$7.76 $14.44 $15.93 $19.64

COMPLETE THIS SECTION FOR ANY SPOUSE OR DEPENDENTS YOU WISH TO COVER ON YOUR SUPPLEMENTAL BENEFITS ...				
COVERED DEPENDENTS	FIRST NAME MIDDLE INITIAL LAST NAME	SOCIAL SECURITY # *XXX-XX-XXXX*	BIRTH DATE *XX/XX/XXXX*	GENDER *MALE / FEMALE*
SPOUSE:				
CHILD:				
CHILD:				
CHILD:				
CHILD:				

BENEFICIARY DESIGNATION(S) SECTION ...

THE DESIGNATED BENEFICARY LISTED BELOW IS FOR THE "COUNTY" PROVIDED LIFE INSURANCE (1X'S ANNUAL SALARY ... UP TO $75,000, BUT NO LESS THAN $25,000 ... AT NO COST TO EMPLOYEE) AND FOR ALL VOLUNTARY LIFE INSURANCE COVERAGES ELECTED THROUGH LINCOLN, ALLSTATE BENEFITS, AND TRANSAMERICA WHOLE LIFE. NOTE: YOUR CONTINGENT BENEFICIARY(IES) WILL RECEIVE BENEFITS ONLY IF THE PRIMARY BENEFICIARY DOES NOT SURVIVE YOU.

PRIMARY BENEFICIARY(IES): *PERCENTAGE AMOUNT MUST EQUAL 100%*					
FIRST NAME	LAST NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

CONTINGENT BENEFICIARY(IES): *PERCENTAGE AMOUNT MUST EQUAL 100%*					
FIRST NAME	LAST NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

BENEFICIARY DESIGNATION(S) FOR THE PRUDENTIAL 401(K) AND 457B PLANS, AND FOR THE LOCAL GOVERNMENT RETIREMENT SYSTEM PLAN ...

GO TO *www.ncplans.prudential.com* AND CREATE AN ACCOUNT TO DESIGNATE YOUR BENEFICIARY(IES).

GO TO *www.nctreasurer.com* > ORBIT AND CREATE AN ACCOUNT TO DESIGNATE YOUR BENEFICIARY(IES).

I agree to the benefit elections as outlined on this Benefits Enrollment Form.

EMPLOYEE SIGNATURE _____ DATE _____