EL PASO COUNTY

E-mail to: employeebenefits@elpasoco.com
or
Fax to: (719) 520-7497

2018 Employee Benefits Election Form

PLEASE PRINT ***PLEASE PRINT***

Name: _____ Social Security Number _____ - _____ - _____
Last First MI (Required)

Department: _____ Home/Cell #: _____ Daytime Phone #: _____

If married to an El Paso County employee, print spouse's name and SSN#: _____

THIS FORM MUST BE SUBMITTED WITHIN 31 DAYS FOLLOWING THE EFFECTIVE DATE

☐ADDING ☐DROPPING ☐NEW HIRE ☐OPEN ENROLLMENT

Reason for Change: _____ Effective Date: _____

Employee Contributions Per Pay Period (Twice Monthly)

A. MEDICAL PLAN **☐Decline Medical**

☐Employee Only $40.71 ☐Employee + Spouse $120.57 ☐Employee + Child(ren) $114.77 ☐Employee + Family $169.46

B. DENTAL PLAN (to enroll, choose one plan, Low or High Option) **☐Decline Dental**

Low Option:

☐Employee Only $7.49 ☐Employee + Spouse $12.58 ☐Employee + Child(ren) $19.46 ☐Employee + Family $28.45

High Option:

☐Employee Only $19.45 ☐Employee + Spouse $32.68 ☐Employee + Child(ren) $50.57 ☐Employee + Family $73.91

C. VISION PLAN **☐Decline Vision**

☐Employee Only $2.99 ☐Employee + Spouse $5.68 ☐Employee + Child(ren) $5.98 ☐Employee + Family $8.79

D. FLEXIBLE SPENDING ACCOUNT (FSA) Note: Each year you must re-enroll in FSA (**deductions taken every pay period**) **☐Decline FSA**

☐Health Care FSA Annual Election $ _____ Annual Maximum $2,600

☐Dependent Care FSA Annual Election $ _____ Annual Maximum $5,000

Employee and Family Member Information:						Enroll/Cancel the Following:				
Last Name	**First Name**	**MI**	**Birth Date**	**Sex M/F**	**SSN**	**Enroll (X)**	**Cancel (X)**	**Medical (X)**	**Dental (X)**	**Vision (X)**
Employee										
Spouse										
Child										
Child										
Child										

By signing below, I understand and agree that:

I have reviewed my employee benefit information, available at www.elpasoco.com - Administrative Offices/Administration and Finance/Benefits Division, and understand the benefit choices available and elect the options checked above. On behalf of my eligible family dependents and myself, I agree to abide by eligibility, enrollment, and election procedures for my El Paso County benefits as outlined in the employee benefit information. If I waived medical coverage, I certify that I have other medical coverage. I am authorizing my employer to reduce my compensation by the amount specified on a pre-tax basis. I understand that I am not permitted to change my elections during the Plan Year unless the change is on account of and consistent with current recognized IRS regulations and change in status events. I acknowledge that I have read all sections of this enrollment form, and I certify on behalf of my eligible family dependents and myself that, to the best of my knowledge, the information shown on this enrollment form, including dependent names and social security numbers, is complete and accurate. I will provide proof of relationship for each enrolled dependent; i.e., spouse: marriage certificate and/or child(ren): birth certificate(s). I understand that it is my responsibility to notify El Paso County Employee Benefits Division **in writing, within 31 days**, of any changes in the eligibility of my dependents and that the Plan is not responsible for informing me of all my rights, benefits and services under the selected healthcare provider.

Knowingly providing false, incomplete, or misleading facts or information on this Election Form or in any other document or website for the purpose of defrauding or attempting to defraud El Paso County's benefit plans is a fraudulent act, which is subject to civil and/or criminal penalties, fines, denial of enrollment in any or all of El Paso County's benefits plans, or as provided in regulations, statutes, and ordinances.

Employee Signature: _____ **Date:** _____

EMPLOYEE BENEFITS DIVISION USE ONLY:

EFFECTIVE DATE: _____ **APPROVED:** _____ **DATE:** _____