

## 2019 Employee Benefits Election Form

PLEASE PRINT

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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 \$48.85   
  Employee + Spouse \$144.69   
  Employee + Child(ren) \$137.73   
  Employee + Family \$203.36

**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 \$2,650

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](http://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:** \_\_\_\_\_