Coverage Election/Waiver for July 1, 2021

Employer Name: Currituck County

Employee **#**: _____: Name: _____
(Last) (Suffix) (First) (MI)

Dual Employee (Spouse) _____

Medical: # 2405	**Monthly Premium**	**Per Pay Check**	**Election**	**Waive**
Employee Only	---$0---	---$0---	_____	_____
Dual Employee/Spouse	---$0---	---$0---	_____	_____
Dual Employee/Family	---$0---	---$0---	_____	_____
Employee/Children	$515.00	$257.50	_____	_____
Employee/Spouse	$465.00	$232.50	_____	_____
Family	$670.00	$335.00	_____	_____
Dental: # 2705				
Employee Only	---$0---	---$0---	_____	_____
Dual Employee/Spouse	---$0---	---$0---	_____	_____
Dual Employee/Family	$ .20	$ .10	_____	_____
Employee/Child(ren)	$10.08	$ 5.04	_____	_____
Employee/Spouse	$30.86	$15.43	_____	_____
Family	$38.78	$19.39	_____	_____
Vision: # 2605				
Employee Only	$ 6.74	$ 3.37	_____	_____
Employee/Child	$12.90	$ 6.45	_____	_____
Employee/Children	$20.94	$10.47	_____	_____
Employee/Spouse	$12.90	$ 6.45	_____	_____
Family	$20.94	$10.47	_____	_____
Flexible Spending:	Monthly Card Fee = $3.00		_____	_____
Medical, Dental, Vision Expenses	(Max $2749.92 - $114.58 PP)		_____	_____
Dependent Care:	(Max $4,999.92 - $208.33 PP)		_____	_____

Special Enrollment Notice and Certification – *Please review and sign below.*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am electing and/or declining enrollment as indicated above. I understand that if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that over coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage). I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. In addition, I understand that if I have a newly eligible dependent as the result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.
By signing below, I acknowledge that I have received my Summary of Benefits and Coverage (SBC) for my selected plan.

_____
(Signature of Employee) (Date of Signature)

Rev 4/30/2021