RENSSELAER COUNTY

EMPLOYEE BENEFITS ENROLLMENT FORM

For information on plans, cost, and coverage, please visit https://info.benetechadvantage.com/rensco

EMPLOYEE

SOCIAL SECURITY NO.	**INSTRUCTIONS:** NEW EMPLOYEE: Complete all **unshaded** areas and sign the form. CHANGES: Enter new or corrected information in the **unshaded** areas. Be sure to include your Social Security No.	ADD	CHANGE	OE	DATE OF HIRE	DEPT CODE	SALARY

LAST NAME	FIRST NAME	M.I.	MAILING ADDRESS	CITY	STATE	ZIP CODE

BIRTH DATE	GENDER	MARITAL STATUS: M-Married S-Single D-Divorced W-Widow L-Legally Separated ▶		MARRIAGE DATE	PHONE #	If you have Medicare Coverage ENTER EFFECTIVE DATE (MM/DD/YYYY) Part A Part B	MEDICARE ID #	EMAIL ADDRESS

IF MARRIED PLEASE LIST SPOUSE FIRST BELOW	If Spouse has Medicare Coverage ENTER EFFECTIVE DATE (MM/DD/YYYY) Part A Part B	MEDICARE ID #	Note: By listing a spouse or dependent you are certifying that you are married and/or that any dependent children are yours by birth, adoption or legal guardianship. You may be required to submit proof such as a marriage certificate, birth certificate, etc. Also, the IRS requires that the County collect the Social Security Number of any covered dependent. The health plans offered are HMOs that require you to use participating providers and that each member have a Primary Care Physician.

SPOUSE & DEPENDENTS

ADD	REMOVE	LAST NAME (If Different)	FIRST NAME	M.I.	SOCIAL SECURITY #	BIRTH DATE	GENDER	RELATIONSHIP

IF MORE SPACE IS NEEDED TO LIST DEPENDENTS, ATTACH ANOTHER FORM. BE SURE TO ENTER YOUR SOCIAL SECURITY NUMBER.

OFFICE USE ONLY

Coverage Effective Date:______________________________

Coverage Cancel Date:______________________________

Full Time: ☐ Hours/pay period ____________________

Part Time: ☐ Hours/pay period ____________________

Active ☐ Retired ☐ On Leave ☐

Survivor ☐

Deceased ☐ Terminate ☐

COBRA ☐ Left Employ ☐

By Request ☐

EMPLOYER REPRESENTATIVE DATE

In the space below please make your benefit selections for health, dental, and vision coverage by checking the box next to “Enroll,” for each benefit you want, then make your plan selection and coverage type. For any benefit you DO NOT want to enroll in, check the box next to “Decline” to waive that benefit. If you have any questions consult your employer. By enrolling in any of these plans, and signing this form, you are authorizing your employer to deduct any required payroll contribution from your pay. **Separate forms are required to enroll in AFLAC and the Flexible Spending Plan.**

BENEFITS

HEALTH INSURANCE

Enroll ☐ Decline ☐

IF ENROLLING, PLEASE SELECT ONE PLAN BELOW, AND ONE COVERAGE TYPE	SINGLE	2PERSON	FAMILY
CDPHP	☐	☐	☐
EMPIRE BLUE CROSS EPO	☐	☐	☐
MVP	☐	☐	☐

DELTA DENTAL

Enroll ☐ Decline ☐

SINGLE ☐

FAMILY ☐

DAVIS VISION

Enroll ☐ Decline ☐

SINGLE ☐

FAMILY ☐

SHERIFF’S DEPt EMPLOYEES ONLY

SHERIFF’S DISABILITY PLAN

Enroll ☐ Decline ☐

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued to my employer by the plans I have selected. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders. I further understand that for HMO benefits, except for emergencies, covered services must be obtained through a participating provider (physician, hospital, laboratory, pharmacy, etc.) unless otherwise noted in a rider, and also that certain services may require a copayment. I hereby authorize any licensed physician, hospital or other health care provider to furnish the plan with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow the plan to administer any benefits. I hereby certify that the information I have provided is true and complete to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Please return the form to Kristin Bertrand in Human Resources via email to kbertrand@rensco.com or fax to 518-270-2636.

EMPLOYEE SIGNATURE **DATE**