Racine County
Benefit Change Form

To add family members to benefits, please submit this form within 30 days of the qualifying event to have coverage the date of that event. If you fail to inform the HR Department within 30 days of the qualifying event, coverage will be effective the first of the following month in which HR receives this notice.

If you wish to cancel coverage for yourself or your dependents, coverage will terminate at the end of the month in which HR receives this notice.

Email the completed form to *humanresources@racinecounty.com*.

EMPLOYEE INFORMATION

Employee Name: _____

Employee #: _____ ***Date of Birth:*** _____

Employee Signature: _____ ***Date:*** _____

ADDING COVERAGE

REASON FOR ADDING COVERAGE

Marriage ☐ ***Medical Support Order*** ☐ ***Birth*** ☐

Adoption/Guardianship (Must Attach Court Documentation) ☐

Loss of Other Coverage (Must Attach Proof of Loss of Coverage) ☐

Date of Change _____

WHAT COVERAGE WOULD YOU LIKE TO ADD?

Health ☐ ***Dental*** ☐ ***Vision*** ☐ ***Life*** ☐ If selecting life insurance, please choose the amount you wish to add. Cost for the amounts are on page 3. If you wish to update your beneficiary, refer to page 4.

SUPPLEMENTAL LIFE FOR SELF:

Select an option in increments of $10,000, with the lowest possible amount being $10,000 and the highest $150,000. **$** _____

SPOUSE LIFE:

Spouses cannot be a dependent if they are already an employee of Racine County. You cannot enroll your spouse unless you are enrolled in your own supplemental life. A spouse cannot be enrolled in a policy that is more than 50% of your own policy.

Select an option in increments of $5,000 with the lowest possible amount being $5,000 and the highest being $50,000. **$** _____

CHILD LIFE:

You cannot enroll your child unless you are enrolled in your own supplemental life.

Select an option in increments of $2,000, with the lowest possible amount being $2,000 and the highest being $10,000. **$** _____

OVER

Please enter the names and requested information of the individuals that you are adding coverage for:

If you are adding a newborn and don't have the SSN yet, please leave that field blank.

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	US CITIZEN IF NO, SEE BELOW
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

If you have checked the box above that your dependent is not a citizen, please sign and date below

**I acknowledge that if my dependent is not a US Citizen, they are here legally and I am able to provide verification of this if needed.*

**I attest that I am being true and honest with the above information and understand that if I am not, insurance benefits for my dependent(s) could be affected.*

Signature: _____ **Date:** _____

EMPLOYEE COVERAGE AUTHORIZATION WARNING:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

DELETING COVERAGE

What coverage would you like to delete?

Health ☐ **Dental** ☐ **Life** ☐ **Vision** ☐ **Date of Change** _____

Please enter the names and information of the individuals that you are deleting coverage for:

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

If deleting dependents from your insurance, you must provide their current address below for COBRA Law purposes:

Name: _____

Address: _____

City, State, Zip: _____ **Phone:** _____