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## NASSAU DISTRICT SCHOOLS EMPLOYEE BENEFITS

### OPEN ENROLLMENT IS HERE!



#### OPTIONS TO CONSIDER...





### ALL CARRIERS ARE STAYING THE SAME!

Medical & Prescription	Florida Blue 🚭 🗑	
Dental & Vision	Humana	
Disability and Life	Affac.	
Cancer, Critical Illness, Hospital & Accident	Affrac Liberty National Life Insurance Company Since 1900	
Life Insurance	Liberty National Life Insurance Company Since 1900	
Legal & ID Theft Protection	LegalShield	

# Humana

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### Dental Plan CS150 (HMO) is no longer available



#### Telemedicine

# You have access to a doctor DAY or NIGHT

Talk to a doctor 24/7/365, anywhere

#### SOME CONDITIONS WE TREAT INCLUDE

Cold & flu symptoms
Bronchitis
Allergies
Pink eye
Sore throat
Respiratory infection
Sinus problems
Rashes
And more!

#### 

#### Talk to a doctor in minutes

FOR 24/7 REMOTE CARE OF ISSUES LIKE COLD & FLU, ALLERGIES & MORE...

WEB: Teladoc.com PHONE: 1-800-TELADOC (835-2362) MOBILE: Teladoc.com/mobile

If medically necessary, a prescription can be sent to your local pharmacy.



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### **HSA Contribution Limit**

Limit	2019	2020	Change
Self-only HDHP coverage	\$3,500	\$3,550	Up \$50
Family HDHP coverage	\$7,000	\$7,100	Up \$100
Catch-up contributions*	\$1,000	\$1,000	No change

\*not adjusted for inflation

#### WHAT'S DIFFERENT THIS YEAR?

### **FSA Limits**

Limit	2019	2020	Change
Health FSA (limit on emplyees' pre-tax contributions)	\$2,700	\$2,750	Up \$50
Dependent care FSA (tax exclusion)*	\$5,000 (\$2,500 if married and filing taxes separately)	\$5,000 (\$2,500 if married and filing taxes separately)	No change

\*not adjusted for inflation

#### **ONLINE TOOLS**













#### Employee Enrollment Form - Florida Blue

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Please type or write (clearly in black or blue in:       Please type or write (clearly in black or blue in:       Sector E Dependent thomaton agents there. If editors agents there is a flag solution of the	Florida Bli	ue 💁 🗑			Employee I	Inrollment	Application			-							
Section A: Current Information       V         Group Name:       Group #:       Division #:       Package #:         Effective Date of Overage: Date of Hire:       Location #:       Employee #:       Job Title:         Work Status:       Actively at Work.       Cobra       Retired Retirement Date:       Paid:       Houry:       Paid:       Houry:       Paid:       Houry:       Paid:       Houry:       Paid:       Houry:       Social Security #:       Last Name:       First Name:       Mil:       Bith Date:       Mil:       Bith Date:       Mil:       Houry:       Paid:       A & B C H N W         Social Security #:       Last Name:       First Name:       Mil:       Bith Date:       Social       A & B C H N W         Social Security #:       Last Name:       First Name:       Mil:       Bith Date:       Social       A & B C H N W         Social Security #:       Last Name:       First Name:       Mil:       Bith Date:       Mil:       Bith Date:       Mil:       Houry:       Paid date:       A & B C H N W         Social Security #:       Last Name:       First Name:       Mil:       Bith Date:       Mil:       Houry:       Houry:       Houry:       A & B C H N W         Social Security #:       Apt #:       Citt	An Independent Licensee of th Blue Cross and Blue Shield Ass	e ociation			Please type or v	write clearly in l	black or blue ink.	Section E: Dependent Inf	Social	ch separate sl	Relation	n to You (John Dec)	Plan Type	Physician	Dependent	n, sign & date Ethnicity op Circle all th A) Asian/Paci B) Black/Afric	e. otional nat apply. ific Islander can American
Concern and the approximation     Concent and the approximation     Concent and the approximation     C	Section A: Current Informati	ion V		Group #:		Division #	Package #	(if different than employee) First Name, M.I.	Security Number:	Birth Date:	()	Parte	E	B Name/ID	Vou St	C) Caribbean	Islander
Enclude Date of Coverage: Date of Nice:	Effective Data of Coverages	Data of Line	Losstian th	Group #.	Int. Titler		Tackage #.				ld (C)	nestic F nestic F ner (O)	alth on c (M or		sting Pa Ju Suppo	N) Native Am	erican
Work Status:       Actively at Work       Cobra         Retirement Date:       Paid:       Hourly         Salary         Open Enrollment         Social Security #;       Last Name:       First Name:       ML:       Birth Date:       MI       Itemportupes information         Social Security #;       Last Name:       First Name:       ML:       Birth Date:       MI       Itemportupes information         Street Address:       Apt. #:       City;       State:       Zp:         County:       Phone:       Martial Status:       Single Married       Norcoed       Widowed       Separate         Physician Name / ID # HMO only:       Existing Patient Language of Preference: optional - for data collection purposes only       Prefer not to answer       Prefer not to answer         Ethnicity optional Check at that apply:       Existing Patient Language of Preference: optional - for data collection purposes only       Prefer not to answer         Ethnicity optional Check at that apply:       Existing Patient Language of Preference: optional - for data collection purposes only       Prefer not to answer         BlueSelect Plan #       BlueChoice (PPO) Plan #       BlueCare (HMO) Plan #       BlueCare (HMO) Plan #       Prefer not to answer         BlueSelect Plan #       Other Plan #       Blue Choice (PO) Plan #       BlueCare (HMO) Plan #       Blue Choice (PO) Plan #	Effective Date of Coverage:	Date of Hire:	Location #:	Employee #:	JOD TITIE:						S CFI	<u>a</u> a a	Seo Seo	5	For You Live Is a	vv) vvnite	
Section B: Employee Information         Social Security #:       Last Name:         First Name:       First Name:         Street Address:       Apt. #         County:       Phone:         Single I Married I Divorced       Widwed         Street Address:       Apt. #         County:       Phone:         Single I Married I Divorced       Widwed         Single I Married I Divorced       Widwed         Street Address:       Conty:         Physician Name / ID # HMO only:       Existing Patient Language of Preference: optional - for data collection purposes only         Physician Name / ID # HMO only:       Existing Patient Language of Preference: optional - for data collection purposes only         Check at that apply:       Asian/Pacific Islander       Black/African American         Check at that apply:       Naine Pacific Islander       Black/African American         Section F: Other Health Insurance Information       The count (ren)       Family         BlueSelect Plan #       Other Plan #       BlueChoic (PPO) Plan #       BlueChoic (PPO) Plan #         BlueSelect Plan #       Other Plan #       BlueChoic (PPO) Plan #       BlueChoic (PPO) Plan #         I am Refusing all Healt Coverage at this time. I understand that if I decide to apply later coverage may not be availiable until the nest: Cancel Date:	Work Status: Actively a	at Work 🗌 Cobr	a 🗌 Retired Retire	ment Date:	Paid: Ho	urly 🗌 Salary [	Open Enrollment									ABC	HNW
Social Security #;       Last Name;       First Name;       M.I.: Birth Date;       Sex:       M = F         Street Address:       Apt. #; City;       State; Zp;       I is the name of each dependent listed above that is manned or has dependent, bild(m) or lives outside of Florida.         County:       Phone;       Marital Status;       Separated         Physician Name / ID # HMO only;       Existing Patient, Language of Preference; optional - for data collection purposes only         Prysician Name / ID # HMO only;       Existing Patient, Canguage of Preference; optional - for data collection purposes only         Prefer not to answer       Prefer not to answer         Ethnicity optional       Caribbean Islander       Hispanic         BlueOptions Plan #       BlueChoice (PO) Plan #       BlueCare (HMO) Plan #         BlueSelect Plan #       BlueChoice (PO) Plan #       BlueCare (HMO) Plan #         I am Refusing all Health Coverage at this time, I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature:       Bale         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.       Converage Health Coverage at this time, I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature:       Converage information         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association. <t< td=""><td>Section B: Employee Inform</td><td>nation</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>ABC</td><td></td></t<>	Section B: Employee Inform	nation														ABC	
Street Address:       Apt. #: City:       State: Zip:         County:       Phone:       Marital Status:         Street Address:       Apt. #: City:       State: Zip:         County:       Phone:       Street Address:         Physician Name / ID # HMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Check all that apply:       Asian/Pacific Islander       Black/African American         Check all that apply:       BlueChoice (PPO) Plan #       BlueCare (HMO) Plan #         BlueSelect Plan #       Other Plan #       BlueChoice (PPO) Plan #         BlueSelect Plan #       Other statist in sumo: und preferance: coverage may not be available until the exclusing all Health Coverage this time. Luncerstand that if I decide to apply later coverage may not be available until the onlage:       Contract #:       [Endetw Date:         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.       Prote Endetw Date:       Contract #:       [Endetw Date:	Social Security #:	Last Name:		First Name:	١	M.I.: Birth Date:	Sex:									ABC	HNW
Street Address:       Apt. #: City:       State:       Zip:         County:       Phone:       Marital Status:       eggaly         Physician Name / ID # HMO only:       Existing Patient Language of Preference: optional - for data collection purposes only       ** you indicated '0' in 'Relation to You' above for any dependents, please explain here:         Physician Name / ID # HMO only:       Existing Patient Language of Preference: optional - for data collection purposes only       ** you indicated '0' in 'Relation to You' above for any dependents, please explain here:         Ethnicity optional       Asian/Pacific Islander       English Spanish Other       Prefer not to answer         Ethnicity optional       Asian/Pacific Islander       Black/African American       Native American         Check all that apply:       Asian/Pacific Islander       *Employee & One Dependent *Employee / County *Internation **       **         BlueOptions Plan #       BlueChoice (PPO) Plan #       BlueCare (HMO) Plan #       One reliater this on-reage information **         I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available       Date:       Proof Heath Carrier Name:       Contract #:       Effective Date:         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.       Date:       Prior E							□ M □ F	List the name of each depe	ndent listed al	bove that is m	arried or h	has depe	ndent child(r	en) or lives outs	ide of Florida.		
County: Prone: Marital Status: Maried Divorced Widowed Separated Vigoe Separated Signal - for data collection purposes only Asian/Pacific Islander Black/African American Caribbean Islander Hispanic Native American White Section C: Health Coverage Level and Plan Information Employee Aspouse Temployee & One Dependent Temployee & One Dependent Section C: Health Coverage (Coverage Information Employee Coverage Information Employee Aspouse Temployee & One Dependent Section C: Health Coverage (Coverage Information Employee Aspouse Temployee & One Dependent Section C: Health Coverage (Coverage Information Employee Aspouse Temployee & One Dependent Section C: Health Coverage at this time, I understand that if I decide to apply later coverage may not be available Intext open or special enrollment period. Signature: Date: Profession C: Barder Coverage at this time, I understand that if I decide to apply later coverage may not be available and the follow of Signature: Date: Profession C: Inter Health Coverage of the Blue Cross and Blue Shield Association.	Street Address:			Apt. #: Cit	ty:	State	e: Zip:							,			
Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Physician Name / ID # HIMO only:       Existing Patient: Language of Preference: optional - for data collection purposes only         Phock all that paping:       Cheat the Coverage Level and Plan Information         Existing Patient:       BlueChoice (PPO) Plan #       BlueChoice (PPO) Plan #       BlueChoice (PPO) Plan #       BlueChoice (PPO) Plan #       Patient: Socorage may not be available until the next open or special enrollment period.       Signature:       Patient: Socorage may not be available until the pate:         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.       Effective Date:       Cancel Date:       List names of all family members that were covered, including yourself:         I understand that any preson who knowin	County:	Phone:		Marita	l Status: gle 🔲 Married 🔲 Di	vorced 🔲 Widd	wed Separated	* If you indicated "O" in "Re	lation to You"	above for any	depender	nts, pleas	e explain he	re:			
Ethnicity optional Check all that apply:       Asian/Pacific Islander       Black/African American       Caribbean Islander       Hispanic       Native American       White         Section C: Health Coverage Level and Plan Information       Imployee Health Coverage:       Employee & Spouse       *Employee & One Dependent       For or o	Physician Name / ID # HMO o	nly: Exist	ing Patient: Languag es 🗍 No 🗍 Engl	e of Preference: opti lish	tional - for data collectio ] Other	on purposes only	Prefer not to answer										
Section C: Health Coverage Level and Plan Information  Employee A Spouse * Employee & One Dependent *	Ethnicity optional Check all that apply: Asi	an/Pacific Islander	Black/African	American 🗌 Caril	bean Islander 🗌 His	spanic 🗌 Native	e American 🗌 Whit	e									
Employee Health Coverage:       Employee       *Employee & Spouse       *Employee & One Dependent       *Employee & One Dependent       Femployee       *Employee       *Employee & One Dependent       Femployee       *Employee & One Dependent       Femployee       *Employee & One Dependent       *Employee       *Employee & O	Section C: Health Coverag	e Level and Pla	n Information														
BlueOptions Plan #       BlueChoice (PPO) Plan #       BlueCare (HMO) Plan #         BlueSelect Plan #       Other Plan #       Medicare #       Pharmacy/Medicare D #         I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the Date:       Medicare #       Pharmacy/Medicare D #         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.       Date:       Contract #:       Contract #:       Effective Date:         Prior Heath Carrier Name:       Cancel Date:       List names of all family members that were covered, including yourself:	Employee Health Coverage: *When available	Employee	*Employee & Spous	e 🗌 *Employee	& One Dependent	*Emplanon	d(ren) 🗌 Family	Section F: Other Health	Insurance Info	ormation This	section		~	process	ing and Prior	Coverage Ir	nformation
BlueSelect Plan #       Other Plan #       Pharmacy/Medicare D #         I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period.       Signature:       Date:         Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.       Fiorida Association.       Fiorida Blue is an Independent to injure, defraud, or deceive any insurer files a statement of claim or an application contract that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application contract that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application contract incertaining any table incomplete or the third degree	BlueOptions Plan #		BlueChoice (PP	PO) Plan #	BlueCar	e (HMO) Plan #		coverage begins? Yes	you or your dep	bendents have	any other	Insurance	age (i	iciuaing†10rida i	lue plans) that	will be in effe	ect after this
I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the Date: Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.	BlueSelect Plan #		Other Plan #					Florida B	lue Contract #	ime you or your	N	Aedicare a	#	Pha bealth insurance i	imacy /Medica	ire D #	v bave bealth
Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.	I am Refusing all Health next open or special enror	Coverage at this ollment period.	time. I understand Signature:	that if I decide to	apply later coverage	may not be av Date	ailable until the e:	coverage; and/or (3) have any Prior Heath Carrier Name	y health coveraç :	ge in the past 12	2 months th	hat this co	verage replac Contract #:	es OR you can a	tach a Certificat	e of Creditable Date:	e Coverage.
I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of	Florida Blue is ar	n Independent	Licensee of the	e Blue Cross an	d Blue Shield Ass	ociation.		Prior Employee Hire Date	:	Cancel	Date:	List nar	mes of all fa	mily members	that were cov	ered, includir	ng yourself:
Clamator an approvation containing any task, mounplete, or insteading information is guily of a reform of the during degree.		·						I understand that any pe claim or an application of	rson who kn containing an	owingly and ly false, inco	with inte mplete, o	ent to inj or mislea	ure, defrau ding inforr	d, or deceive a nation is guilty	ny insurer fil of a felony c	es a stateme of the third d	ent of legree.

#### Employee Change Application - Florida Blue



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Dependent Change Complete Section C



Applicable to Group Administrator: The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected. By submitting cancellation(s) you represent that you have not collected a premium from the employees/ dependents for coverage after the requested termination date.

Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.

#### Florida Blue 💩 🕅

			Ret	elati o Yo	ion Du	Pla Typ	an pe		Be		(N/N)	De	pen	dent	Eth Cir	nici cle	<b>ty</b> o all t	ptic hat	onal app	oly.
Last Name: ( <i>if different than_employee</i> ) First Name, M.I.	Social Security Number:	Birth Date:	Spouse (S)	Child (C)	Other (O)*	Health	Vision	Sex (M or F)	Check if Disab	Physician Name/ID HMO only	Existing Patient	You Support	Lives With You	Is a Student	A) / B) E C) ( H) I N) I W)	Asiar Black Carib Hispa Nativ Whit	/Pac /Afri bea anic e An e	cific I can n Isla neric	Islan Ame ande ande	der rica r
								[							А	В	С	Η	Ν	V
								[							A	В	С	Η	N	V
								[							А	В	С	Н	Ν	V
							Π	ſ	٦			П	Π		A	В	С	Н	Ν	V

List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

#### \* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section D: Other Health Insurance Information This section must be

d Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage maluding Florida Blue plans) that will be in effect after this coverage begins? Yes No Florida Blue Contract #

Pharmacy/Medicare D # Medicare #

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Prior Health Carrier Name			Contract #:	Effective Date:
Prior Employee Hire Date:	Cancel Date:	List ı your	names of all family members t self:	hat were covered, including
Employee Signature:				Date:

#### **Employee Enrollment Form - Humana**

#### **Dental and Vision Benefits**

#### Enroliment Form

#### Group Name: Nassau County School Board

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Please complete	the follo	owing	informa	tion					
Social Security No.	Last Name			First		м	Date of	Birth	
Home Address				Home	Phone		G	nder	
				(	)		M	F	
City		State	Zip Code	Busin	ess Phone		Dental F	acility #	
				( )	)		(navis of	91	
List All Your Elig	jible Dep	ende	nts to be	e Cover	ed		1		
First	M	La	st	Enrolment	Social Sec. No	were racing a	Gender	Date of Birt	h
Spouse				Dental		nazuo ony	M F		
Child				Dental Vision			M F		
Child				Dental Vision			M F		
Child				Dental Vision			M F		
Child				Dental Vision			M F		
Effective Date	E-mail Addr	ess					Date of	Hire	

Please Check your Dental and Monthly Premiums	Vision Enroll	ment Choice		
Plan Name	Bental HS205	Dental Advantage	PPO	Vision HV130
Employee Only	\$17.98	\$26.30	\$34.16	\$ 6.84
Employee + One Dependent	\$35.58	\$49.82	\$64.70	N/A
Employee + Spouse	N/A	N/A	N/A	\$13.66
Employee + Child(ren)	N/A	N/A	N/A	\$17.08
Employee + Family	\$63.54	\$82.02	\$106.52	\$23.90

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contributions from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Date:

Signature:

### Employee Change Form -Humana

Humana Employee Chan	ige Form			
Please print clearly and fill in each a	pplicable circle.			
Current Medical Group number		Benefit number		Class/Division
Current Dental/VisionGroup number 78701	10	Proposed Effective	Date for change:	_//
Company name Nassau County School Bo	ard	Company city Fe	rnandina Beach	State Florida
Employee Information and Cha	anges			A
Please provide employee information and it	ndicate all applicable em	splayee changes.		
Last name	First name	М	Social Security number	
• Change Medical benefit/class to: Ber	refit number:		Class/Division:	
<ul> <li>Change or Select Employee Print</li> </ul>	nary Care Physician (H).	VIO and POS only):		
Primary care physician:			Physician ID:	
Change Dental benefit/class to: Bene	fit number:		Class/Division:	
Change or Select Employee Prin	nary Care Dentist lappi	icable to AZ, CA.	FL GA. L. IN, KS. KY. MO	), NC, OH, TN, TX and WV only
Primary dentist:		A	Facility number:	
Channe Basic Life benefit/class to: B	anefit number		Class/Division:	
Change base the belief brand line b	Create and the company		Classromorum.	
Primary beneficiary name: Last	Group number:		First name	M
Secondary beneficiary name: Last	t name		First name	M
Change Voluntary Life Beneficia	erv: Group number:			
Primary beneficiary name: Last	t name		First name	M
Secondary beneficiary name: Last	t name		First name	М
Change Vision benefit/class to: Benef	fit number:		Class/Division:	
Cancel My Coverage for the following p	roducts: C Medical		O Voluntary Life O	Short-term Income Protectio
	Q Vision Q H	ite. 1 Savings Accou	nt (HSA) 🔾 Health Can	e FSA. 🔾 Dependent Care FS
Qualifying Event Information		4		
Please indicate the qualifying event date an	d reason for employee o	or dependent chang	ges below:	
Qualifying event date: / /				
Reason for change:				
<ul> <li>Re-hire</li> </ul>	C Marriage		<ul> <li>Spouse term</li> </ul>	ninates employment
<ul> <li>Employer contribution ceases</li> </ul>	<ul> <li>Legal separation</li> </ul>		🗅 Spouse's em	ployer terminates coverage
<ul> <li>Dependent birth / adoption</li> </ul>	C Divorce		Spouse char	iges from full-time to
<ul> <li>Dependent change to full-time student</li> </ul>	Q Spouse deceased		Dither:	nproyment
Change Address Information				
Address change applies to:				

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C Employee only C Employee and all cov	rred dependents				
<ul> <li>Only for the following dependent (please</li> </ul>	print full name): Last name		First name	N	4
New street address		Apt / Suit	e / PO Box number		
City	State	Zip code	County		
Email address		Phone mu	mber		
GN-80124-CG 11/2006	1		Reorden#	GN-99955-CG	3/200

	Group Number 7870	19	Social Security Number			
Dependent Change	85					
Please complete this section	n for all dependent chan	ges.				
Last name		First name			Date of birth	1.1
Social Security number	Gender:	O Female O Ma	e Relationship: Q	Spouse C	Child Q Dr	ther:
Dependent status (if applica	able): 🖸 Full-time stude	ent 🔾 Disabled	If disabled, indica	ate reason:		
Add or Delete dependence	endent to/from my current.	plan for the followir	ng products: Q Medic	al Janu Ližn	O Dental	🔾 Basic Life
Change or Select Prim	ary Care Physician HW	D and POS only):	C volum	ary tre	C VISION	
Primary care physician:		1.		Physician I	D:	
Change or Select DHN	10 (applicable to AL, AZ, C/	A. FL. GA. IL. IN, KS.	KY, MO, NC, OH, TN, TX	and W/ only	d:	
Primary dentist:				Sacility num	nber:	
Last name		First name	M		Date of birth	
Social Security number	Gender:	🔾 Female 🔾 Ma	le Relationship: 🔾	Spouse C	Child 🔾 Ot	ther:
Dependent status (if applica	able): 🛛 Full-time stude	ent 🗘 Disabled	If disabled, indica	ite reason:		
Add or C Delete depe	endent to/from my current	plan for the followir	ng products: 🤉 Medic	al	Q Dental	O Basic Life
Changes or Solart Brim	any Care Diversion Util	and ROS anbib	C Volum	ary Life	U Vision	
Change of Select Film	ary care ruysician/nim	and Posienty).		Manufacture II	n.	
Primary care prijsioan:	Alizzalizable to ULAZ		EX MO NO OU TH TY	, mysician i and WV cell	JC	
Change of Select DHN	Disprane to AL AL, O	n, na on, ita ina kas	KI, BO, DO, OR, DR, D	and minority	//-	
Primary denost:				-acity nun	nder:	
Lastanna		Cost come			Data of birth	
Cocial Cocurity number	Gandar	O Famala O Mai	la Dalatioachin: Cl	Sooura C	Child CD Dr	//
Social Security Humber Demondorat stratur, (if applice	denuer	or remain or main	H dirabled index	spouse Ca		nel.
Add or C Delete dore	notest tolices my current	nian for the followin	a products: O Media	3	C Dental	O Rasir Life
Private of the presence of pr	protect on a data of carrent	promition the following	G Volunt	ary Life	Q Vision	Contraction of the second
Change or Select Prim	ary Care Physician HM	0 and POS only):				
Primary care physician:				<sup>a</sup> hysician I	D:	
Change or Select DHN	IO(applicable to AL, AZ, C)	4, FL, GA, IL, IN, KS,	KI, MO, NC, OH, TN, TX	and W/ only	yk:	
Primary dentist:				Sacility num	nber:	
Last name		First name	M		Date of birth	1.1
Social Security number	Gender:	🔾 Female 🔾 Ma	le Relationship: 🔾	Spouse 🔾	Child 🔾 Dr	ther:
Dependent status (if applica	able): 🔾 Full-time stude	ent 🔾 Disabled	If disabled, indica	ate reason:		
Add or Delete dependence	andent to/from my current (	plan for the followir	ng products: O Medic	al any life	Dental	<ul> <li>Basic Life</li> </ul>
Change or Select Prim	ary Care Physician HW	D and POS only?	- Polan	any the	A 1000	
Primary care physician:				Physician II	D:	
Change or Select DHN	O(applicable to AL, AZ, C/	A. FL. GA. IL. IN. KS.	KK MO, NC, OH, TN, TX	and W/ only	d:	
Primare dentist:	an industry and and and a		ind and und out out of	Sacility num	nber:	
				serd and		
Signature - please sig	n below if requesting cha	nges				
mployee or legal representat	five signature:				Date:	
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rame and relationship of leg-	a représentative.					
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# DISTRICT WEBSITE PROVIDES VALUABLE RESOURCES

### WWW.NASSAU.K12.FL.US/HR





#### PLEASE REFER TO YOUR 2020-2021 INSURANCE & BENEFITS INFORMATION GUIDE

