NASSAU DISTRICT SCHOOLS

EMPLOYEE BENEFITS

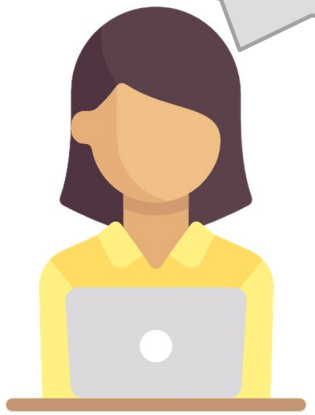
OPEN ENROLLMENT IS HERE!

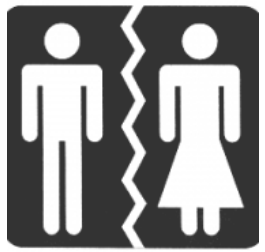
July 31st

OPTIONS TO CONSIDER…

QUALIFIED LIFE EVENTS

When can I make a change to my benefits?



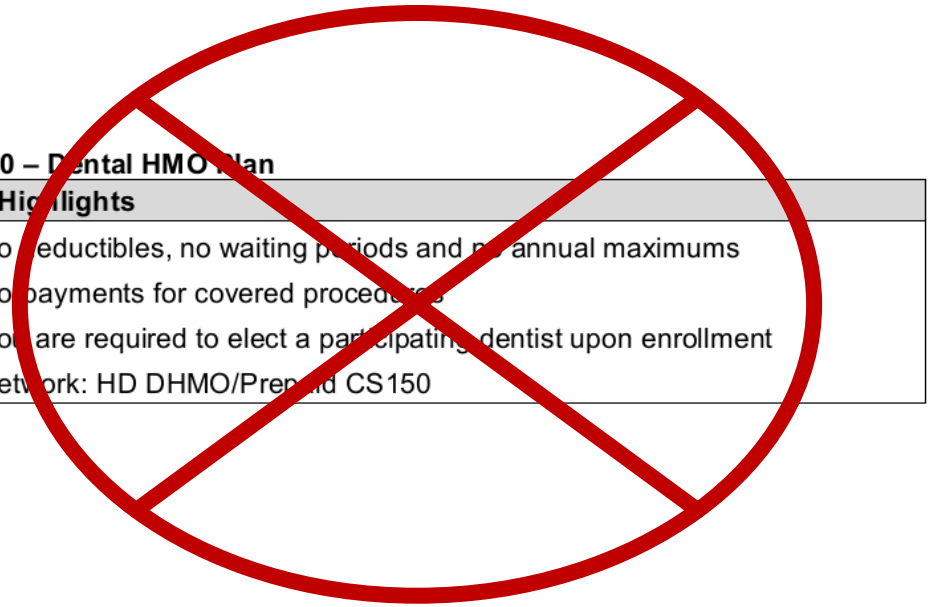


ALL CARRIERS ARE STAYING THE SAME!

Medical & Prescription	Florida Blue
Dental & Vision	Humana
Disability and Life	Aflac
Cancer, Critical Illness, Hospital & Accident	Aflac; Liberty National Life Insurance Company Since 1900
Life Insurance	Liberty National Life Insurance Company Since 1900; New York Life; Aflac
Legal & ID Theft Protection	LegalShield

Humana

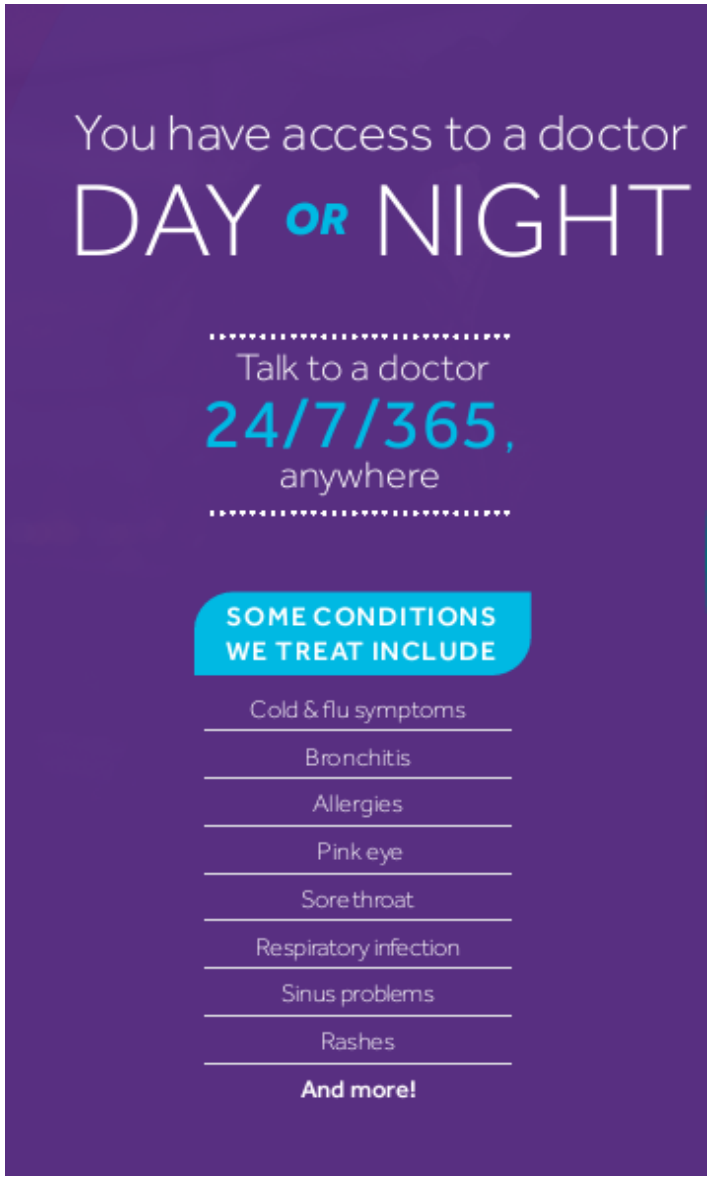
Dental Plan CS150 (HMO) is no longer available

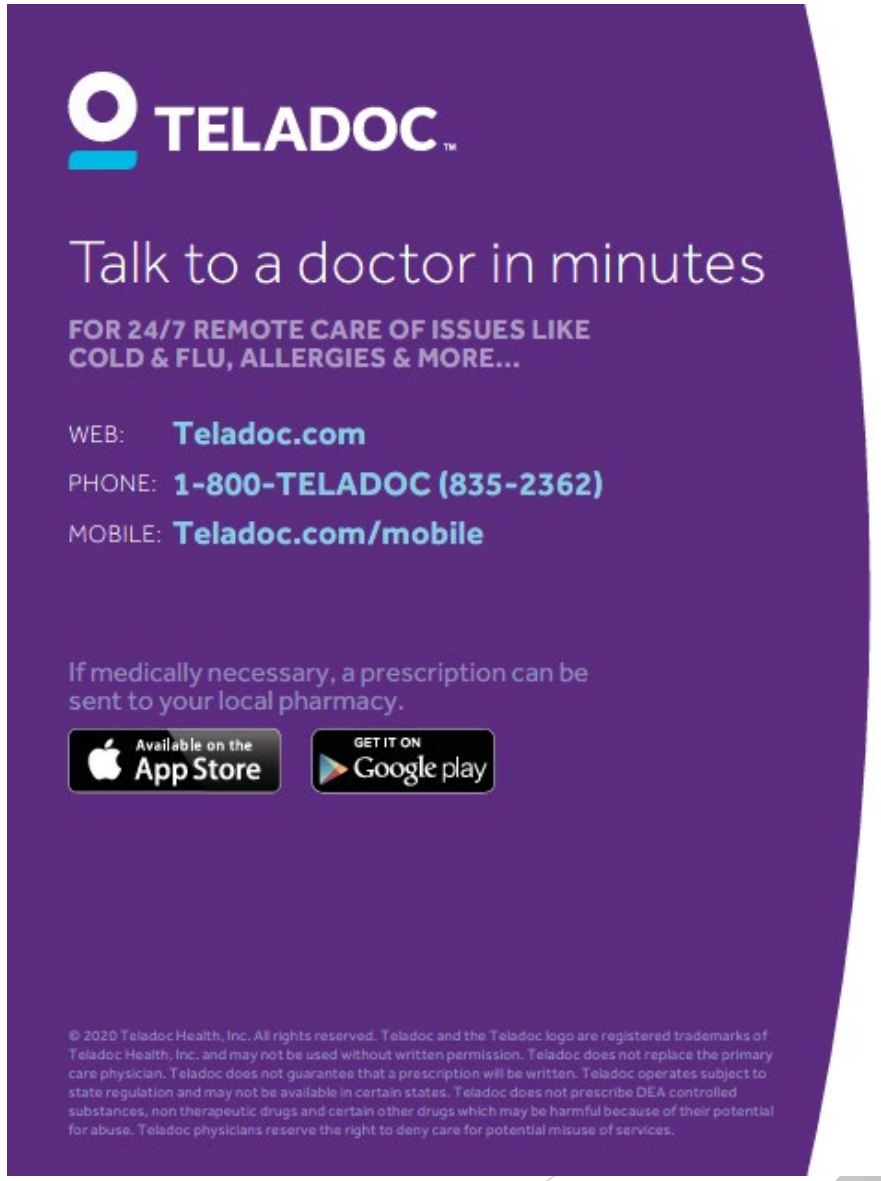


CS150 – Dental HMO Plan

Plan Highlights
• No deductibles, no waiting periods and no annual maximums • Copayments for covered procedures • You are required to elect a participating dentist upon enrollment • Network: HD DHMO/Prepaid CS150

Telemedicine





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?

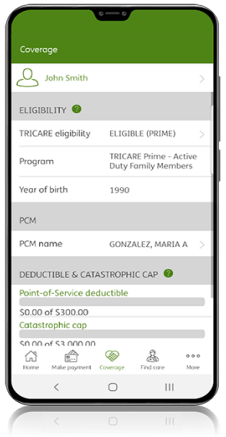
FSA Limits

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**

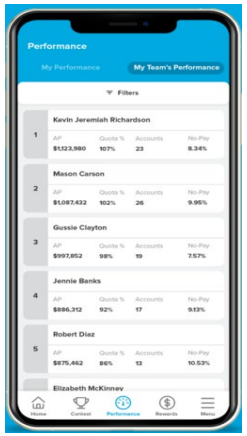
*not adjusted for inflation

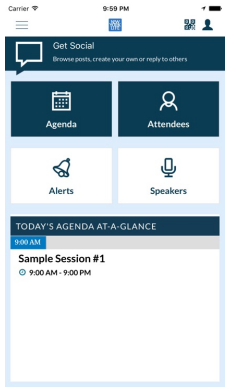
ONLINE TOOLS

Florida Blue

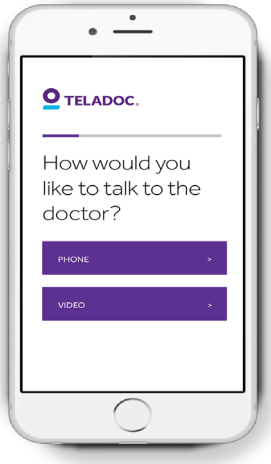


Humana



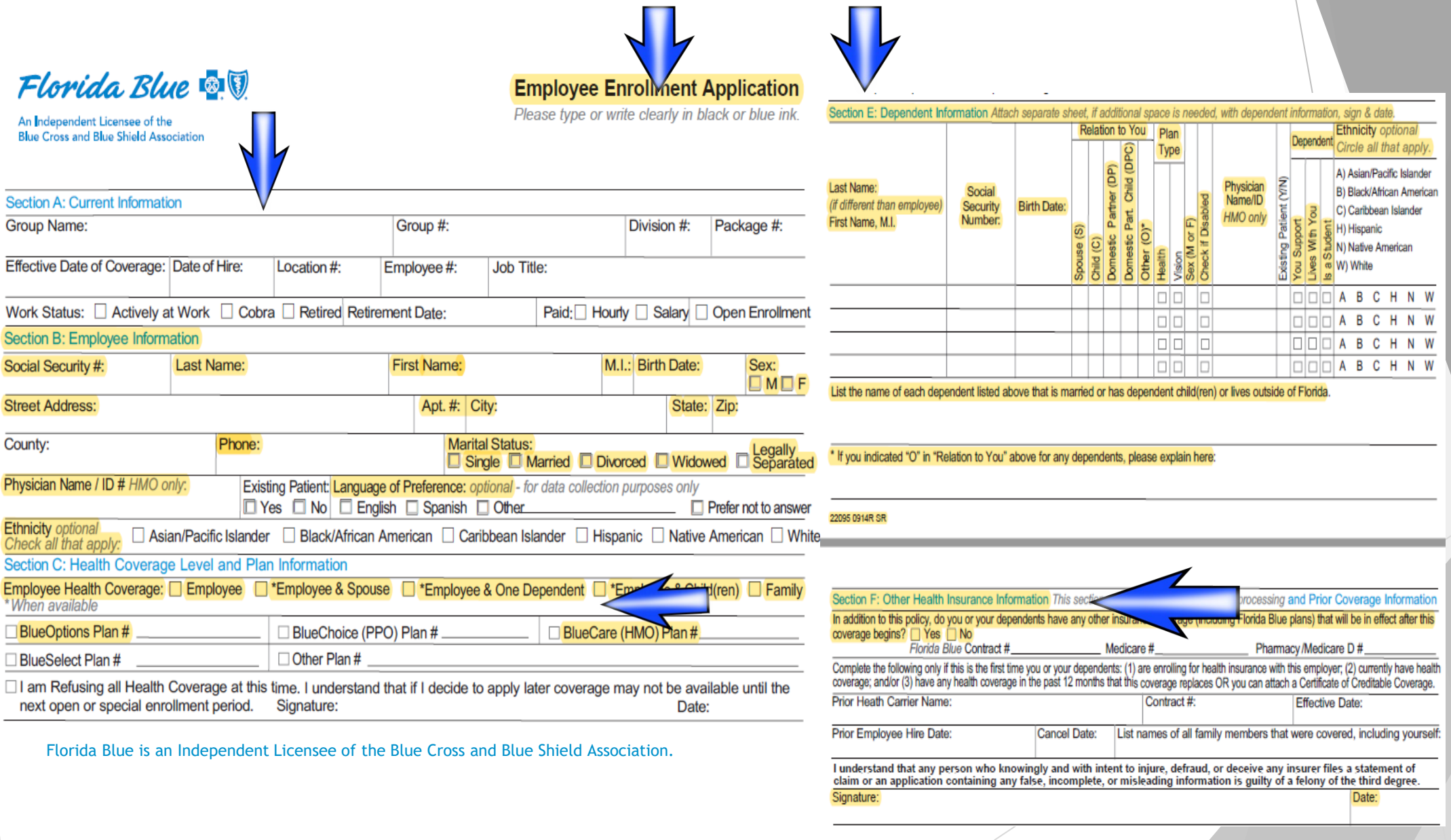


NEW YORK LIFE



TELADOC

Employee Enrollment Form - Florida Blue



Florida Blue
An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Enrollment Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name: | Group #: | Division #: | Package #:

Effective Date of Coverage: | Date of Hire: | Location #: | Employee #: | Job Title:

Work Status: ☐ Actively at Work ☐ Cobra ☐ Retired | Retirement Date: | Paid: ☐ Hourly ☐ Salary ☐ Open Enrollment

Section B: Employee Information

Social Security #: | Last Name: | First Name: | M.I.: | Birth Date: | Sex: ☐ M ☐ F

Street Address: | Apt. #: | City: | State: | Zip:

County: | Phone: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Physician Name / ID # *HMO only:* | Existing Patient: ☐ Yes ☐ No | Language of Preference: *optional - for data collection purposes only* ☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

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

Employee Health Coverage: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Em[illegible]d(ren) ☐ Family
*When available

☐ BlueOptions Plan # _____ ☐ BlueChoice (PPO) Plan # _____ ☐ BlueCare (HMO) Plan # _____

☐ BlueSelect Plan # _____ ☐ Other 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: Date:

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

Section E: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign & date.*

Last Name: (if different than employee) First Name, M.I.	Social Security Number:	Birth Date:	Relation to You: Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Plan Type: Health	Vision	Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	Lives With You	Is a Student	Ethnicity *optional* Circle all that apply.
								☐	☐		☐			☐	☐	☐	A B C H N W
								☐	☐		☐			☐	☐	☐	A B C H N W
								☐	☐		☐			☐	☐	☐	A B C H N W
								☐	☐		☐			☐	☐	☐	A B C H N W

A) Asian/Pacific Islander
B) Black/African American
C) Caribbean Islander
H) Hispanic
N) Native American
W) White

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:

22095 0914R SR

Section F: Other Health Insurance Information *This sect[illegible]* [illegible]processing and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insura[illegible]ge (including Florida Blue plans) that will be in effect after this coverage begins? ☐ Yes ☐ No

Florida Blue Contract # _____ Medicare # _____ Pharmacy/Medicare D # _____

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.

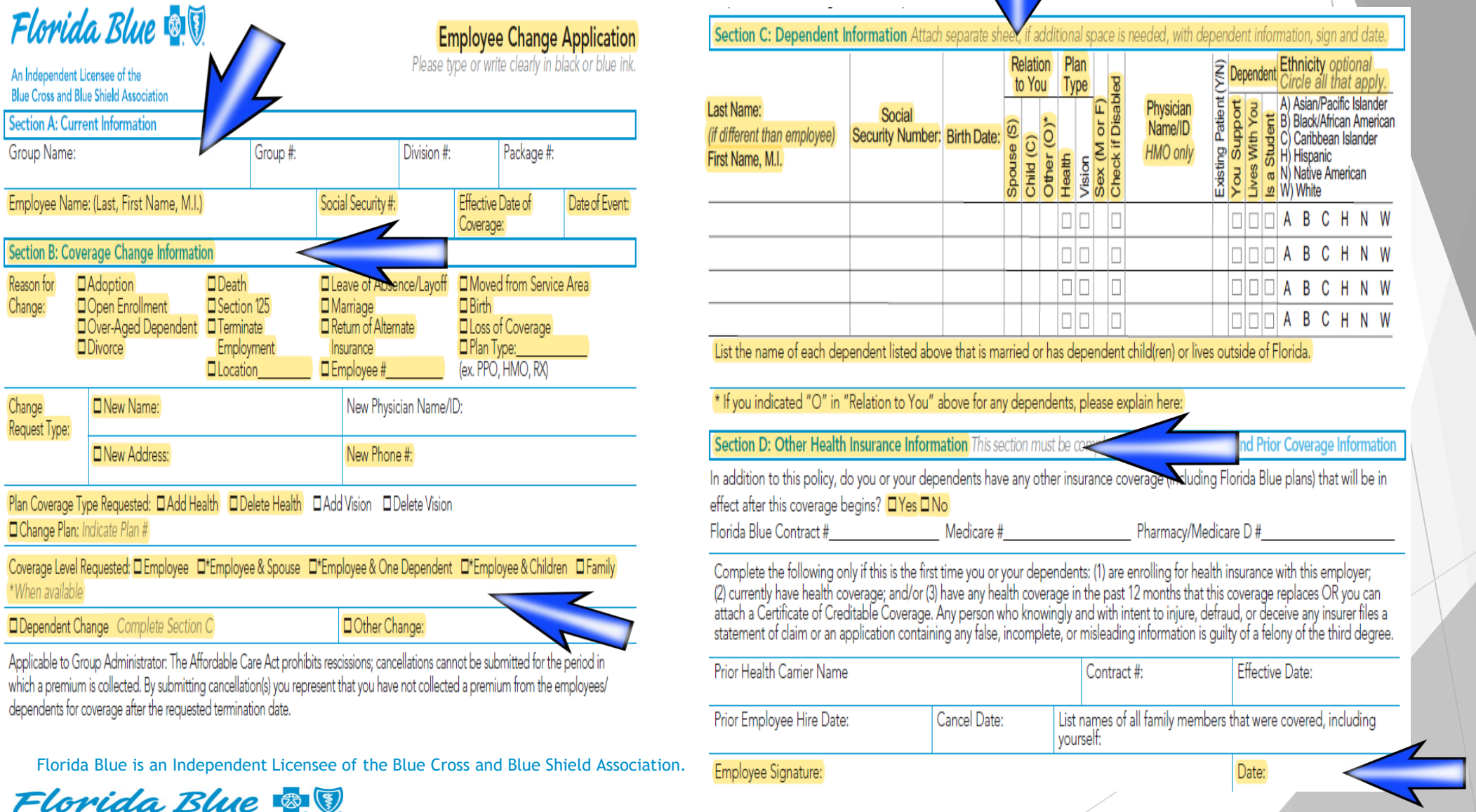
Prior Heath Carrier Name: | Contract #: | Effective Date:

Prior Employee Hire Date: | Cancel Date: | List names of all family members that were covered, including yourself:

I understand that 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.

Signature: | Date:

Employee Change Application – Florida Blue



Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Change Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:	Group #:	Division #:	Package #:
Employee Name: (Last, First Name, M.I.)	Social Security #:	Effective Date of Coverage:	Date of Event:

Section B: Coverage Change Information

Reason for Change:
- ☐ Adoption
- ☐ Open Enrollment
- ☐ Over-Aged Dependent
- ☐ Divorce
- ☐ Death
- ☐ Section 125
- ☐ Terminate Employment
- ☐ Location_____
- ☐ Leave of Absence/Layoff
- ☐ Marriage
- ☐ Return of Alternate Insurance
- ☐ Employee #_____
- ☐ Moved from Service Area
- ☐ Birth
- ☐ Loss of Coverage
- ☐ Plan Type:_____ (ex. PPO, HMO, RX)

Change Request Type:	☐ New Name:	New Physician Name/ID:
	☐ New Address:	New Phone #:

Plan Coverage Type Requested: ☐ Add Health ☐ Delete Health ☐ Add Vision ☐ Delete Vision
☐ Change Plan: *Indicate Plan #*

Coverage Level Requested: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Children ☐ Family
**When available*

☐ Dependent Change *Complete Section C* ☐ Other Change:

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.

Section C: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign and date.*

Last Name: *(if different than employee)* First Name, M.I.	Social Security Number:	Birth Date:	Relation to You: Spouse (S)	Relation to You: Child (C)	Relation to You: Other (O)*	Plan Type: Health	Plan Type: Vision	Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	Dependent: Lives With You	Dependent: Is a Student	Ethnicity *optional Circle all that apply.*
						☐	☐		☐			☐	☐	☐	A B C H N W
						☐	☐		☐			☐	☐	☐	A B C H N W
						☐	☐		☐			☐	☐	☐	A B C H N W
						☐	☐		☐			☐	☐	☐	A B C H N W

A) Asian/Pacific Islander
B) Black/African American
C) Caribbean Islander
H) Hispanic
N) Native American
W) White

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 com…* …nd Prior Coverage Information

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

Florida Blue Contract #_____ Medicare #_____ Pharmacy/Medicare D #_____

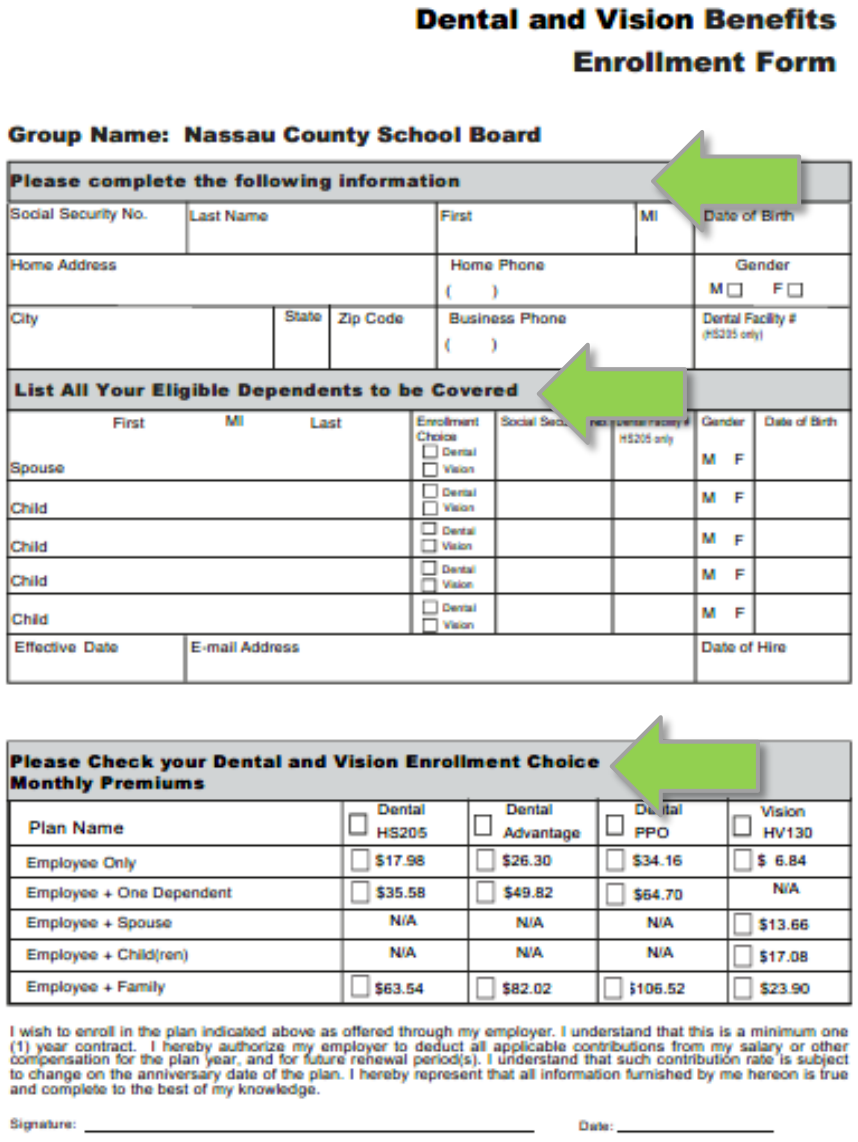
Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable 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 names of all family members that were covered, including yourself:
Employee Signature:		Date:

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

Florida Blue

Employee Enrollment Form -Humana



Dental and Vision Benefits
Enrollment Form

Group Name: Nassau County School Board

Please complete the following information				
Social Security No.	Last Name	First	MI	Date of Birth
Home Address		Home Phone ( )		Gender M ☐ F ☐
City	State / Zip Code	Business Phone ( )		Dental Facility # (HS205 only)

List All Your Eligible Dependents to be Covered						
	First	MI	Last	Enrollment Choice	Social Sec... / Dental Facility # HS205 only	Gender	Date of Birth
Spouse				☐ Dental ☐ Vision		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 Address	Date of Hire

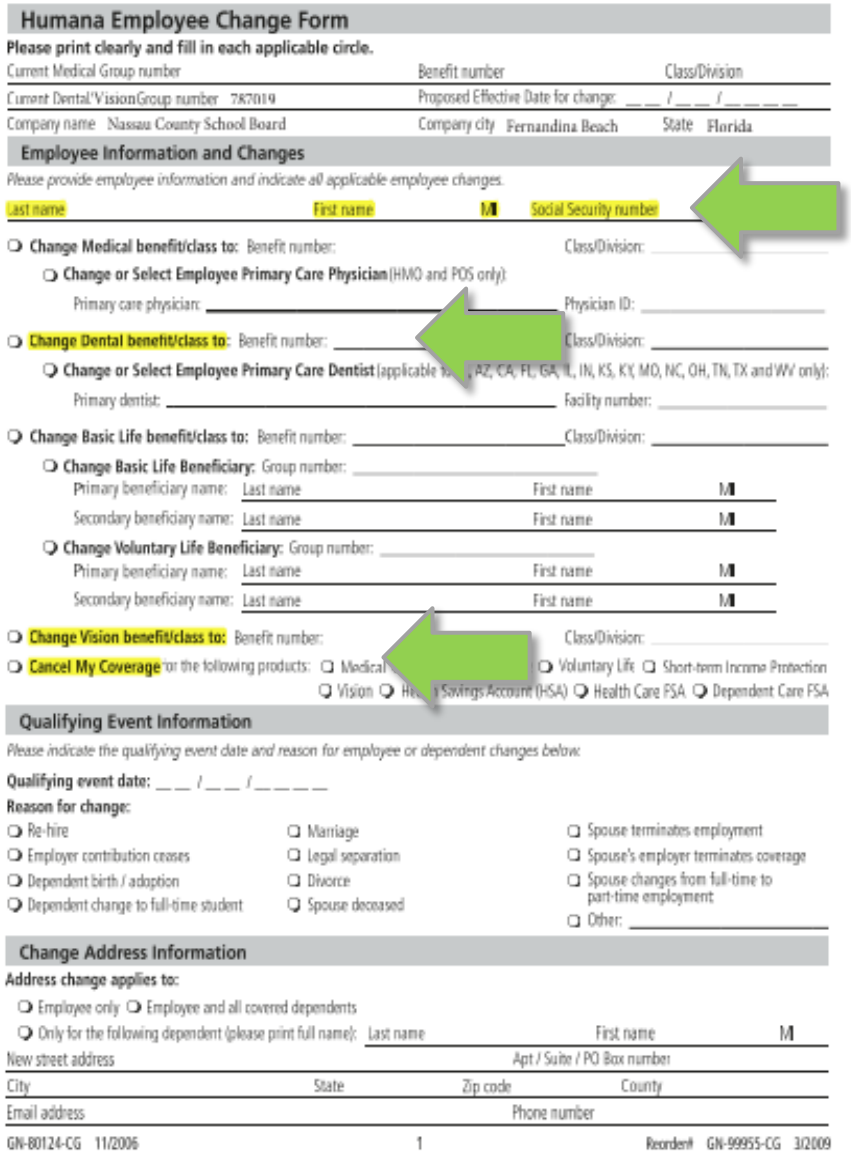
Please Check your Dental and Vision Enrollment Choice
Monthly Premiums

Plan Name	☐ Dental HS205	☐ Dental Advantage	☐ Dental 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.

Signature: _____ Date: _____

Employee Change Form -Humana



Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Current Medical Group number | Benefit number | Class/Division

Current Dental/VisionGroup number 787019 | Proposed Effective Date for change: ___ / ___ / ___ ___ ___ ___

Company name Nassau County School Board | Company city Fernandina Beach | State Florida

Employee Information and Changes

Please provide employee information and indicate all applicable employee changes.

Last name | First name | MI | Social Security number

❍ **Change Medical benefit/class to:** Benefit number: | Class/Division:

❍ **Change or Select Employee Primary Care Physician** (HMO and POS only)

Primary care physician: | Physician ID:

❍ **Change Dental benefit/class to:** Benefit number: | Class/Division:

❍ **Change or Select Employee Primary Care Dentist** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: | Facility number:

❍ **Change Basic Life benefit/class to:** Benefit number: | Class/Division:

❍ **Change Basic Life Beneficiary:** Group number:

Primary beneficiary name: Last name | First name | MI

Secondary beneficiary name: Last name | First name | MI

❍ **Change Voluntary Life Beneficiary:** Group number:

Primary beneficiary name: Last name | First name | MI

Secondary beneficiary name: Last name | First name | MI

❍ **Change Vision benefit/class to:** Benefit number: | Class/Division:

❍ **Cancel My Coverage** for the following products: ❍ Medical ❍ Voluntary Life ❍ Short-term Income Protection ❍ Vision ❍ Health Savings Account (HSA) ❍ Health Care FSA ❍ Dependent Care FSA

Qualifying Event Information

Please indicate the qualifying event date and reason for employee or dependent changes below.

Qualifying event date: ___ ___ / ___ ___ / ___ ___ ___ ___

Reason for change:

- ❍ Re-hire
- ❍ Employer contribution ceases
- ❍ Dependent birth / adoption
- ❍ Dependent change to full-time student
- ❍ Marriage
- ❍ Legal separation
- ❍ Divorce
- ❍ Spouse deceased
- ❍ Spouse terminates employment
- ❍ Spouse's employer terminates coverage
- ❍ Spouse changes from full-time to part-time employment
- ❍ Other:

Change Address Information

Address change applies to:

❍ Employee only ❍ Employee and all covered dependents

❍ Only for the following dependent (please print full name): Last name | First name | M

New street address | Apt / Suite / PO Box number

City | State | Zip code | County

Email address | Phone number

GN-80124-CG 11/2006 1 Reorder# GN-99955-CG 3/2009

Group Number 787019 | Social Security Number

Dependent Changes

Please complete this section for all dependent changes.

1 Last name | First name | MI | Date of birth ___ / ___ / ___ ___

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only)

Primary care physician: | Physician ID:

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: | Facility number:

2 Last name | First name | MI | Date of birth ___ / ___ / ___ ___

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only)

Primary care physician: | Physician ID:

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: | Facility number:

3 Last name | First name | MI | Date of birth ___ / ___ / ___ ___

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only)

Primary care physician: | Physician ID:

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: | Facility number:

4 Last name | First name | MI | Date of birth / /

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only)

Primary care physician: | Physician ID:

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: | Facility number:

Signature - please sign below if requesting changes

Employee or legal representative signature: | Date:

Name and relationship of legal representative:

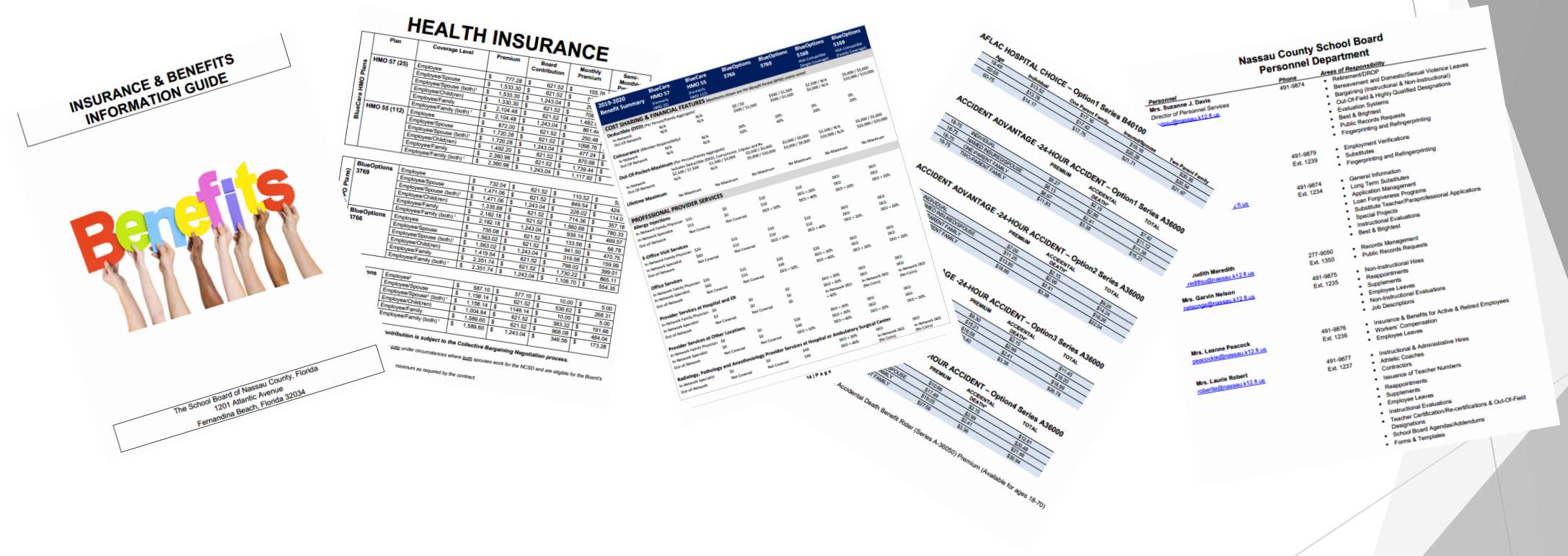
GN-80124-CG 11/2006 2 Reorder# GN-99955-CG 3/2009

DISTRICT WEBSITE PROVIDES VALUABLE RESOURCES

WWW.NASSAU.K12.FL.US/HR

QUESTIONS?

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



Leanne Peacock - (904) 491-9876