2020 Notice of Open Enrollment & Acknowledgement Form

(PLEASE BE ADVISED THAT THIS IS NOT AN ENROLLMENT FORM)

Nassau County School District
Human Resources Department
1201 Atlantic Avenue
Fernandina Beach, FL 32034

All pages of the Notice of Open Enrollment and Acknowledgement Form are required for all employees, including those who are part-time and not currently eligible for benefits. **This is not an enrollment form. In addition to this Notice of Open Enrollment and Acknowledgement Form, any elections for coverage, changes and/or cancellations for existing coverage require additional paperwork.** Employees who wish to waive group health insurance coverage do not need to complete a separate packet to waive coverage, proper completion of this packet satisfies waiver requirements for Florida Blue.

Please carefully read through the following sections and complete each section. If you have any questions relating to the paperwork, your options and/or your current benefit elections, please contact Leanne Peacock in the Human Resources Department for assistance.

SECTION I: Employee Information

Please print clearly

Employee Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

School/Location:

☐ BES ☐ CES ☐ CIS ☐ CMS ☐ ELH ☐ FBHS ☐ FBMS ☐ HES
☐ HMSR ☐ SES ☐ WES ☐ WNHS ☐ YES ☐ YHS ☐ YMS ☐ YPS
☐ ESE DEPT ☐ ADULT ED ☐ TRANSPORTATION
☐ FACILITIES ☐ CAREER ED ☐ COUNTY OFFICE
☐ OPERATIONS ☐ OTHER SITE: ______________________________

SECTION II: Plan Participation

All employees must complete the following eight statements.

NOTE: Checking the elect box does not imply coverage. Additional forms are required.

Insurance	*Check one box for each insurance:*					
Florida Blue Health	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
Humana Dental	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
Humana Vision	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
Trustmark Optional Life	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
Liberty National Life	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
AFLAC Supplemental	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
LegalShield	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible
New York Life	☐ Elect	☐ Maintain	☐ Change	☐ Cancel	☐ Waive	☐ Not Eligible

SECTION III: Dependent Enrollment Requirements (Information Only)

Employees who cover dependents (spouses and/or children) on group insurance policies through the Nassau County School District are responsible to adhere to certification requirements. Please review the Dependent Enrollment Requirements & Worksheet which may be found on the Human Resources Department Website at www.nassau.k12.fl.us/hr.

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SECTION IV: Notice of Special Enrollment Rights

You must be given a written description of special enrollment rights by the date you are offered the opportunity to enroll. Notice of Special Enrollment Rights must be given to an employee who declines group health coverage during his/her initial eligibility period. You should return a signed copy of this notice to your employer if you decline coverage because you have other health coverage.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in a health care plan offered by your employer, provided that you request enrollment, by submission of an individual application to Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI), within 30 days after the other coverage ends, unless the coverage under which you or your dependent was enrolled was Medicaid or a Children's Health Insurance Plan (CHIP), in which case you have 60 days from the date you lose coverage to request enrollment in your employer's health plan.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment by submission of an individual application to BCBSF/HOI, within 30 days after the marriage, birth, adoption, or placement for adoption.

The effective date of coverage for an individual and/or dependents as a result of marriage, birth, adoption, or placement for adoption is the date of the event.

Additionally, you have Special Enrollment Rights if you or your dependent becomes eligible for the optional State premium assistance program, if available in your State. You must request enrollment in your employer's group health plan within 60 days of the date you become eligible for the State premium assistance program. If you and/or your dependents decline enrollment because you have coverage under another group health plan or other health insurance coverage, you are required to complete the statement below and return it to your Group Administrator. If you fail to do so, you may not be entitled to special enrollment in your employer's group health plan when your other coverage terminates.

Please understand that you will not be entitled to special enrollment if loss of eligibility for coverage is the result of termination of coverage for failure to pay premiums on a timely basis or for cause. Voluntary Termination of Coverage does not constitute loss of eligibility of coverage.

NOTE: For purposes of clarification, cause is defined as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage is defined as loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, the discontinuance of any contributions toward the health coverage plan by the employer, or you lose coverage under Medicaid or a Children's Health Insurance Plan (CHIP).

Please check one box.

☐ I currently have or have elected health care coverage through the Nassau County School District's group health plan.

☐ I am not eligible for group health care coverage at this time.

☐ I am declining enrollment in the Nassau County School District's group health plan and I do not have other health care coverage.

☐ I am declining enrollment in Nassau County School District's group health plan and I currently have other health care coverage.

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SECTION V: Acknowledgements

________ INITIAL — I have been provided with the 2020-2021 Insurance & Benefits Information Guide, in hardcopy or electronic format, which includes the Health Insurance Marketplace Model Notice. I understand that a copy is available on the Nassau County School District's website (www.nassau.k12.fl.us) under the Human Resources Department page.

________ INITIAL — I have been provided with the 2020-2021 Summary of Benefits and Coverage (SBC) and the Glossary of Health Coverage & Medical Terms in compliance with the Patient Protection and Affordable Care Act ("PPACA"), in hardcopy or electronic format. I understand that a copy is available on the Nassau County School District's website (www.nassau.k12.fl.us) under the Human Resources Department page.

________ INITIAL — I acknowledge that employees must work a minimum of 25 hours per week to meet eligibility requirements to participate in group health, dental and vision insurance plans.

________ INITIAL — I acknowledge that I have been given the opportunity to enroll in group insurance coverage(s) with the Nassau County School District, providing I meet eligibility requirements, and the opportunity to attend the virtual Open Enrollment Fair. The Open Enrollment information is posted on www.nassau.k12.fl.us under the Human Resources Department page. Insurance representatives are available during Open Enrollment by telephone to answer my questions. Contact numbers are available in the 2020-2021 Insurance & Benefits Information Guide.

________ INITIAL — I acknowledge that if I refuse any coverage during Open Enrollment, I may not enroll until the next open enrollment period (August 2021), unless there is a life-changing event as permitted by the insurance carriers. I am only permitted to elect insurance outside of Open Enrollment if I experience an involuntary loss of coverage, through no fault of my own, such as loss of coverage under a spouse's health plan, etc., or unless I have a qualifying lifestyle event such as marriage, or the addition of a new dependent through birth or adoption. I understand I need to enroll within 30 days of the event or wait until the following year's open enrollment to make any changes.

________ INITIAL — I acknowledge that I am responsible to complete the appropriate paperwork with each respective insurance carrier to elect, make changes or to cancel insurance coverage. If I do not complete the proper paperwork, ***my changes will not go into effect***.

________ INITIAL — As part of the Patient Protection and Affordable Care Act, I acknowledge that as of January 1, 2014, health insurance coverage was mandatory. If I do not elect group health insurance coverage through the Nassau County School District during Open Enrollment, I will **not** be permitted to make elections in order to be compliant with the Patient Protection and Affordable Care Act.

It is my responsibility to elect group health insurance coverage **now** through the group health plan or to secure coverage through the Health Insurance Marketplace or an independent insurance company in order to be compliant with the Patient Protection and Affordable Care Act. I understand the decision to waive coverage through the group health plan has consequences. I acknowledge that if I decline my employer coverage, which is considered affordable and adequate under the Patient Protection and Affordable Care Act, I may not qualify for government subsidies to purchase individual health insurance.

SECTION VI: Certification

I certify that the information I have provided in this Notice of Open Enrollment and Acknowledgement Form is true and accurate.

________________________________ PRINTED NAME

________________ DATE

________________________________ SIGNATURE