

To Be Completed By Risk Management

Group Number 649032	Division	Billing Category	Date of Employment
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To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name Okaloosa County BOCC			Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

Coverage Check with Risk Management about coverage options available to you and Evidence Of Insurability requirements.

Vision

Voluntary Balanced Care Vision

Coverage requested for You, your Spouse & Children You & your Spouse You only You & your Children (no Spouse)

<i>List dependents to enroll or delete.</i> (Last name if different, First, Middle Initial)	Sex		Date of Birth	<i>List dependents to enroll or delete.</i> (Attach sheet for additional dependents if needed.)	Sex		Date of Birth
	M	F			M	F	
Spouse				Child 2			
Child 1				Child 3			

Vision Insurance Waiver: Contributory Vision Insurance

The insurance coverage available to me and my dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Enrollment Penalty.

I decline Vision insurance for myself. I decline Vision insurance for one or more dependents.

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____