Okaloosa County Board of County Commissioners

HRA Enrollment Form
Plan Year October 1, 2020 – September 30, 2021

Personal Information

Employee Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

SSN: _____

Birth Date: _____ Department: _____

Spouse's Name: _____
If additional card is requested

Plan Information

I hereby certify that I have minimal essential health insurance coverage as defined by the Affordable Care Act. I understand that by declining health coverage through Okaloosa County BCC, I authorize participation in the County's HRA program. I also understand I cannot revoke or change this election during the plan year unless I have a qualifying change in family or job status that is consistent with my change in election. I may then revoke my prior election if an election event occurs. As a result of my declination of health care coverage I will receive a HRA with a balance of $1,200.00 for the 2020-2021 plan year. I understand that HRA funds can be used only for qualifying medical, dental, and vision expenses, and the funds do not roll over from year to year; they will expire after the grace period of 12-15-2021.

Employee Certification:

By signing below, I confirm my enrollment in the Okaloosa County BCC HRA for plan year 10/1/2020-9/30/2021.

Signature: _____ Date: _____

Employee Declination:

By signing below, I confirm my declination in the Okaloosa BCC HRA for plan year 10/1/2020-9/30/2021.

Signature: _____ Date: _____

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association Serving Residents and Businesses of Florida

Important Information regarding your 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).

☐ I hereby certify that I am declining enrollment in my employer's group health plan for ☐ myself and/or ☐ dependents because I or they currently **have** other health care coverage; or

☐ I hereby certify that I am declining enrollment in my employer's group health plan and I **do not** currently have other health care coverage.

_____	_____
Print name	Date
_____	_____
Signature	Social Security Number
_____	_____
Group name	Group #

15741-0309