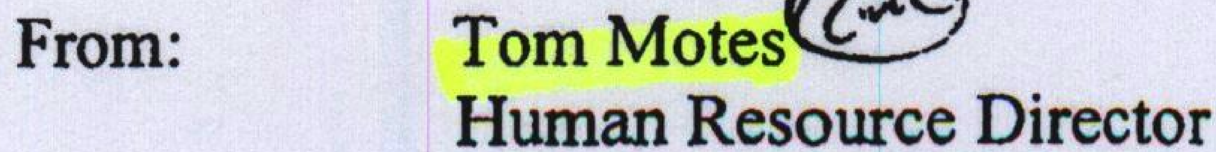
Volusia County
FLORIDA

PERSONNEL DIVISION

To: All Health Coverage Enrollees Date: 7/23/08



From: Tom Motes
Human Resource Director

Subject: Dual Employee – Split Coverage Plan

The County of Volusia has implemented a "split plan" for employees covered under the Health Partnership Plans. The requirements for participation in this program are:

1. Both the employee and his/her spouse must be employed by the County of Volusia.
2. Both employees must be eligible for the health coverage benefit.
3. Both employees must have the same type of coverage (i.e., both employees must be covered under Health Partnership plan for the same level of coverage)

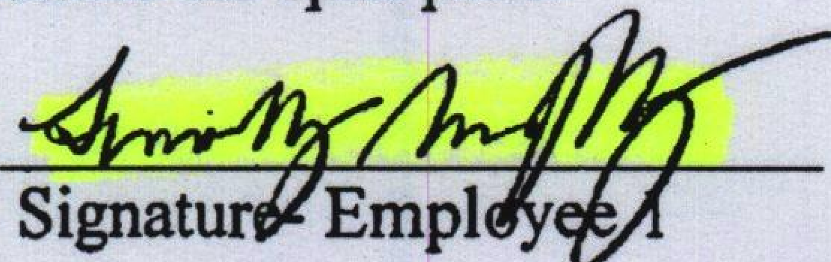
The benefits of this program are lower bi-weekly premiums if you currently have dependent coverage for your children.

If you meet the requirements outlined above and are interested in participating in this program, please complete the section below and return this form to the Personnel Services along with a copy of your marriage certificate.

If you have any questions, please contact Personnel at extension 5137.

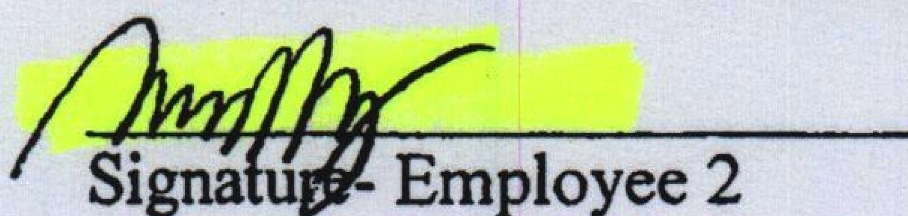
We Timothy Jolley (Please print name) and Mary Jolley (Please print name) meet the requirements

for participation in the split plan program through the County of Volusia please enroll us under the split plan.



Signature- Employee 1 Social Security Number [redacted] Date 8/2/10

Department [redacted]



Signature- Employee 2 Social Security Number [redacted] Date 8/2/10

Department Legal

230 N. Woodland Blvd., Suite 262 • DeLand, FL 32720-4607
Tel: 386-736-5951 (West Volusia) • 386-257-6029 (Daytona Beach) • 386-423-3300 (New Smyrna Beach) • Fax: 386-740-5149

www.volusia.org

The County of Volusia, Florida's Flexible Benefits Plan

For Plan Year Beginning 01/01/07 and Ending 12/31/07

IMPORTANT! YOU MUST EITHER USE THE COUNTY'S ENROLLMENT WEBSITE, OR COMPLETE & RETURN THIS FORM TO PERSONNEL DIVISION, ***NO LATER THAN NOVEMBER 13, 2006***

PLEASE PRINT	DEPARTMENT Legal	WORK PHONE 386 405-0867

YOUR NAME Mary G. Jolley
YOUR SOCIAL SECURITY NUMBER [redacted]
YOUR STREET ADDRESS [redacted]
CITY [redacted]

IMPORTANT!

If you are making changes, cancellations or adding new coverage's, additional enrollment or change forms are needed. Contact Personnel at (386) 740-5137, or (386) 736-5951.

FULL TIME	PART TIME	SPLIT PLAN (Both County Employees)	TOBACCO USER	INCENTIVE
☑	☐	☑ YES ☐ NO SPOUSE Timothy Jolley	☐ YES ☑ NO	$ 100

OPTION 1 - MEDICAL COVERAGE

✓		Indiv	Single Parent	Couple	Family
✓	HEALTH PARTNERSHIP PLAN - with Dental Coverage				✓
	No Coverage (*proof of other coverage required!*)				

OPTION 2 - GROUP TERM LIFE INSURANCE

✓		Core Amount	Additional Amount	Your Age
✓	Core Benefit (*Sun Life*)			41
	Additional Amount (*Minnesota Life*)			

OPTION 3 - SUPPLEMENTAL COVERAGES

✓		Indiv	Single Parent	Couple	Family
	Safeguard Universal II Dental Plan				
✓	Vision Plan	✓			
	Heart Care				
	Critical Illness $______ Benefit Amount				

OPTION 4 - CANCER INSURANCE

?

✓		Option 1	Option 2	Coverage For Individual	Coverage For Family
	American Heritage Insurance				
	No Coverage				

OPTION 5 - FLEXIBLE SPENDING ACCOUNTS

✓		Annual Contribution Amount	Direct Deposit of Reimbursement Checks?
✓	Medical Expense Spending Account	$	☑ Yes, I want Direct Deposit
	Dependent Care Spending Account	$	☐ No, I want to receive checks
	No Coverage		

For Personnel Use Only

8/2/10
Well 1 385
Split F
Vision EE
STD
LTD
Life
102001

This Agreement is subject to the terms of the Volusia County Flexible Benefits Plan, in effect and as may be amended from time to time. I understand my elections as stated on this form shall be governed and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws and revokes any prior election and compensation agreement relating to this Plan. I acknowledge that I have read and understand the terms and conditions printed on the reverse side of this form. If the cost for the benefits I have elected exceed my flexdollar allocation, I authorize the balance to be payroll deducted over 26 pay periods

8/2/10
Date

X [signature]
Signature (*Required*)

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EBS | ATLANTA | LOS ANGELES

County of Volusia
Personnel Services
230 N Woodland Blvd, Ste 262
DeLand, FL 32720-4670
(386) 740-5137

ID 20821
LOC 102001

HPP

Health Partnership Plan
Group Enrollment Form

Group Name: County of Volusia | Group # 2081

Employee Name: JOLLEY (Last) Timothy (First) M. (M I) — Home Phone: [redacted]

Home Address: [redacted] Street address

Mailing address: [redacted]

City State Zip Code

Social Security Number	Date of Birth			
[redacted]	11/11/66	☑ Active ☐ Retired ☐ COBRA	☑ Male ☐ Female	☐ Single ☐ Widowed ☐ Legally Separated ☑ Married ☐ Divorced

Effective Date	Employment Date	Occupation	Hours worked per week
8/2/10	3/97	Program Manager	☐ Under 20 ☐ 20-29 ☐ 30-39 ☑ 40+

Coverage Election.

☑ HPP	☐ Employee only	☐ Employee + 1 or 2 Children	☐ Couple	☑ Family	☐ No Coverage
☐ Vision	☐ Employee only	☐ Employee + 1 or 2 Children	☐ Couple	☐ Family	☐ No Coverage

LIST ONLY ELIGIBLE FAMILY MEMBERS TO BE COVERED:

Name	M	V	Gender	Date of Birth	Social Security Number	Relationship

If you have elected to cover your spouse in the area provided above, please indicate your marriage date ______________

If you or a family member had coverage within 63 days of the effective date of this plan, please provide a copy of the certificate of creditable coverage along with this form.

Are you or your dependent(s) covered under another group plan? ☑ Yes ☐ No If yes, ☐ Employee ☐ My Dependent(s)

Plan Name and Address. ______________ Group Plan # ______________ Effective Date ______________

Spouses Employer ______________ Phone #: ______________

COVERAGE ACCEPTANCE (Read before signing)

I hereby (1) enroll for the coverage(s) for which I am or may become eligible under this Plan, (2) authorize the required deductions, if any, from my earnings, and (3) certify that all information disclosed on this form is correct

[signature]
SIGNATURE OF APPLICANT — DATE 8/2/10

REFUSAL OF COVERAGE

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health coverage, you may in the furture be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days after your other coverage ends In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty days after the marriage, birth or adoption.

I am REFUSING COVERAGE for: ☐ Employee

Reason for REFUSAL: ______________

SIGNATURE OF APPLICANT — DATE

x/c/c/trans/hpp enrollment jeff revised