FBMC
BENEFITS MANAGEMENT
P.O. Box 10789
Tallahassee, FL 32302-2789

COLLEGE of CENTRAL FLORIDA

OPEN ENROLLMENT/CHANGE IN STATUS FORM

Plan Year January 1, 2024 through December 31, 2024

LAST NAME	FIRST NAME	MI	HOME PHONE

EMPLOYEE ID	HOME ADDRESS (STREET)	CITY	STATE	ZIP

BIRTH DATE (MM/DD/YY)			EMAIL ADDRESS
	☐ Male ☐ Female	☐ Single ☐ Married	

ENROLLMENT STATUS				REP	EFFECTIVE DATE
☐ New Employee	☐ Open Enrollment	☐ Change In Status	☐ Administrative Adjustment		

OFFICE USE ONLY

FORM INSTRUCTIONS: All eligible Employees must complete an Enrollment Form to receive desired coverage. You must complete this entire Enrollment Form and return it to Employee Benefits at The COLLEGE OF CENTRAL FLORIDA to ensure enrollment in the benefits selected.

When choosing coverage, please check one box per section below. Costs are shown calculated on a Per Pay Basis. Please ensure you select Pre-Tax or Post-Tax below your Medical Benefits Selections when selecting Spouse, Children or Family Options.

MEDICAL COVERAGE OPTIONS	BlueOptions PPO Silver 05774	BlueOptions PPO Gold 03359	BlueOptions HDHP Silver 05195 + HSA	BlueOptions HDHP Silver Indiv. 05194 + HSA Emplyee ONLY	Deduction
Employee Only	☐ $0.00	☐ $0.00	☐ N/A	☐ $0.00	☐ Post-Tax
Employee +Spouse	☐ $387.00	☐ $332.50	☐ $297.50		
Employee + Children	☐ $281.50	☐ $226.50	☐ $204.50		
Employee + Family	☐ $668.50	☐ $579.50	☐ $544.50		

☐ Pre-Tax ☐ Post-Tax **Please select Pre-Tax or Post-Tax for Spouse, Children or Family**

Tax

DENTAL / VISION COVERAGE OPTIONS	DV-(Plan C)	Deduction
DV-Plan C Employee Only	☐ $0.00 Opting out of Health Benefits Plan Code CE – Dental/Vision Only	

DENTAL COVERAGE OPTIONS - PER PAY RATES					
COVERAGE LEVEL	Employee Only	+ Spouse	+ Children	+ Family	**Premium**
Ameritas Low Dental Plan	☐ $11.14	☐ $24.18	☐ $28.36	☐ $39.64	
Ameritas High Dental Plan	☐ $17.84	☐ $38.32	☐ $45.44	☐ $63.22	
☐ **Decline Coverage**					

VISION COVERAGE OPTIONS - MONTHLY RATES					
COVERAGE LEVEL	Employee Only	+ Spouse	+ Children	+ Family	**Premium**
Ameritas VSP	☐ $4.34	☐ $8.76	☐ $9.28	☐ $13.50	
Ameritas EYE MED	☐ $3.66	☐ $7.36	☐ $7.80	☐ $11.36	
☐ **Decline Coverage**					

TOTAL:

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PLEASE READ AND SIGN REVERSE

VOLUNTARY LIFE INSURANCE OPTIONS	Standard Insurance				
	Select on of the following:				Deduction
	Level of Coverage	Cost of Coverage			
Basic Life	2x Salary Employer Paid				
Supplemental Life Calculation $0.277 Per $1,000 Maximum: $500,000	☐ 1x Salary____________ * 0.277=				
	☐ 2x Salry____________ * 2 *0.277=				
	☐ 3x Salary____________ * 3 *0.277=				
	☐ ADD Coverage ☐ Drop Coverage ☐ Keep Coverage ☐ Decline Coverage				

LIFE INSURANCE OPTIONS	Standard Insurance		Deduction
		Rate Per Pay	
Standard Life - Dependent Life Plans	☐ Dependent Life Insurance Plan CBD1 $5,000 / $2,500	$0.50	
	☐ Dependent Life Insurance Plan CBD2 $10,000 / $5,000	$1.00	
	☐ Dependent Life Insurance Plan CBD3 $20,000 / $10,000	$2.00	
		TOTAL	

DEPENDENT INFORMATION

Instructions: All eligible dependents must be listed here to be covered. Proof is required to add any eligible dependent.

Last Name	First Name	MI	Relationship	Sex	Social Security #	DOB	Medical	Dental	Vision

BENEFICIARY INFORMATION

All Employees must complete beneficiary information below. This beneficiary information will supercede all previous designations on file with FBMC.

	%	Name	DOB	Address (Street State, City, Zip	Relationship
Primary					
Contingent					

BENEFICIARY INFORMATION

To make changes to your beneficiary information please contact the HR department at (The COLLEGE OF CENTRAL FLORIDA).

I hereby authorize (The COLLEGE OF CENTRAL FLORIDA) to deduct the cost of my benefits each month. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT (The COLLEGE OF CENTRAL FLORIDA) AND FBMC BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN (The COLLEGE OF CENTRAL FLORIDA) BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM.

I represent that the statements on this application are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. 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. F.S. Section 817.234(1)(b) (2001).

_______________________________ _______________
Employee Signature Date

_______________________________ _______________
Benefits Administrator Signature Date

PLEASE READ AND SIGN REVERSE