JEFFERSON COUNTY
Employment Application Form

Notice to Applicant

This application is for the Jefferson County Board of County Commissioners. The Schools, Sheriff, Clerk of Court, Supervisor of Elections, the Tax Collector and the Property Appraiser each have their own applications.

Application for current vacancies is made by completion and submittal of a employment application prior to the advertised deadline. The application must be completely filled out. You may attach a resume but it cannot be accepted in place of the completed application.

A separate application is required for each position for which you apply. No other application form is acceptable.

Driver's license policy requirements

If the position which you are applying requires the operation of a County vehicle or road maintenance equipment, you are required to possess and maintain a driving record that meets the County's standards for insurance coverage. If you are offered this position, this offer of employment is contingent upon your meeting the standards listed below. You must submit a copy of your State of Florida driving transcript upon employment. Inability to meet the following standards will prevent your employment:

A. Record must be free of the following violations in the past three (3) years:

Suspended or revoked license	Reckless driving
D.U.I or D.W.I.	Vehicular homicide
Fleeing or attempting to elude police	Drag racing
Three or more accidents and/or violations	

B. Record must have no more than one moving violation (parking, muffler, etc. will not be considered as a moving violation) in a year period.

Drug Free Workplace Policy

1. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance or alcohol is prohibited in the workplace of County Government.
2. Sanctions to be taken against employees for violation of this policy shall result in appropriate personnel action, up to and including discharge and/ or as an alternative, requiring employee participation in an approved drug abuse assistance or rehabilitation program. These actions shall be in accordance with the Jefferson County Personnel Policy.

This page is for your information!

NOTES

ONLY FULL-TIME EMPLOYEES (OR PART-TIME EMPLOYEES WORKING AT LEAST 32 HOURS PER WEEK) ARE ELIGIBLE FOR HEALTH INSURANCE WITH CAPITAL HEALTH PLAN.

EFFECTIVE 1/1/08, DIRECT DEPOSIT IS MANDATORY FOR ALL NEW HIRES.

Jefferson County

EMPLOYMENT APPLICATION FORM

Jefferson County is an Equal Employment Employer. We consider applicants for all positions without regards to race, color, national origin, sex, age, disability, marital status, religion or any other legally protected status.

DATE _____

POSITION APPLYING FOR: _____

Instructions

Application must be typewritten or printed legibly in ink. All questions must be answered. Applications which are not complete will not be considered. If space is not sufficient for complete answers or you wish to furnish additional information, attach sheets of the same size as this application, and number answers to correspond with questions.

PERSONAL HISTORY

1. Full Name:

_____

LAST NAME FIRST MIDDLE ABBV.

_____

RESIDENCE ADDRESS

_____

CITY COUNTY STATE ZIP CODE

_____

TELEPHONE NUMBER (HOME) (OTHER)

2. Other: list all other names you have used including circumstances and time periods you used them. (For example: former name(s), alias(es), or nickname(s).

NAME	CIRCUMSTANCE	DATES FROM MO./TR.	DATES TO MO./YR.

3. If you are under 18 years of age, can you provide required proof of your eligibility to work?
____ Yes ____ No

4. Social Security Number: _____-___-_____

5. If you are not a U.S. Citizen do you possess an I-151 Card, an I-1551, or an I-94 Card stamped "employment authorized" ____ Yes ____ No

6. Can you travel if your job requires it? ____ Yes ____ No

7. Have you ever filed an application with the County before? ____ Yes ____ No

8. Have you ever been employed by the County before? ____ Yes ____ No

EDUCATION / TRAINING

1. High School & Address	Date Started	Date Stopped	Years Completed	Did you Graduate?	Type of diploma

2. * College / University & Address	Date Started	Date Stopped	Credit Hrs. Earned	Graduate?	Degree or Certificate

*Attach diploma or transcript from last institution of higher education attended.
Major _____ Minor _____

3. Other Schools (Trade, Vocational Business or Military):

Name & Address	Dates attended	Area of Study	Credit Hrs. Earned	Graduate?	Degree or Certificate

4. Describe any awards, honors, citations, positions held in school or since.

_____

_____

_____

_____

5. Foreign languages: Speak _____ ___ Fluent ___ Good ___ Fair

Read _____ ___ ___ ___

Write _____ ___ ___ ___

6. Indicate any type of special licenses (pilot, radio operator, etc).

_____

_____

_____

7. If you received a certificate or license for this training, indicate where license issued and date of expiration.

_____

Certificate / License No.: _____

8. Describe any word processing or computer skills and list all software used:

_____

_____

_____

_____

_____

9. State approximate number of words per minute: Typing _____ Shorthand _____

10. Indicate any special skills you possess and equipment you can use which may be related to the job you are applying for:

_____

_____

_____

_____

_____

11. May we contact your present employer? ___ Yes ___ No

12. On what date are you available for work? _____

13. Are you available to work ___ Full Time ___ Part Time ___ Shift Work ___ Nights or Weekend

EMPLOYMENT HISTORY

1. List chronologically all employment beginning with present employment, including part-time employment. All time should be accounted for. If unemployed for a period give dates.

Name & Address of Employer	Dates Worked	Salary	Title or Position	Name of Supervisor	Reason for leaving
Name____ Address ____ City, State, Zip____ Phone____			___ Full ___ Part-time		
Name____ Address____ City, State, Zip____ Phone____			___ Full ___ Part-time		
Name____ Address____ City, State, Zip____ Phone____			___ Full ___ Part-time		
Name____ Address____ City, State, Zip____ Phone____			___ Full ___ Part-time		
Name____ Address____ City, State, Zip____ Phone____			___ Full ___ Part-time		

2. Have you ever been dismissed or asked to resign or had any disciplinary action taken against you from any employment or position you have held? ___ Yes ___ No

3. Have you resigned, or left a job by mutual agreement following allegations of misconduct or unsatisfactory job performance? ___ Yes ___ No If yes to #2 or #3, please provide details.

____
____
____

4. Do you own a business, or are you a partner or corporate officer in any business or organization not listed previously as a current or former employer? ___ Yes ___ No

5. Does this business do business with the County or Sheriffs Office? ___ Yes ___ No If yes to questions #4 or #5, Please provide name and address of business, corporation or organization and describe your relationship or position.

____
____
____

RESIDENCES

1. Actual places of residences for the past three (3) years - list chronologically

Dates: from	To	Apt. No.	Street Address	City	County	State

ARREST HISTORY / COURT DATA

1. Have you ever been convicted of a felony? ___ Yes ___ No
If Yes give details. _____

DRIVING HISTORY

Answer if you will be required to operate a vehicle as part of your job.

1. Are you a licensed Florida automobile operator or chauffeur? ___ Yes ___ No License No._____ Date of Expiration: _____
Restrictions: _____

2. Do you hold or have ever held an operator or chauffeur license in another state? ___ Yes ___ No
If yes, please provide state(s), name used and approximate dates license(s) was/were held._____

3. Have you received during the past five (5) years a ticket or been charged with a traffic violation?
___ Yes ___ No

4. Have you ever been denied issuance of a license or have you ever had a license suspended or revoked? ___ Yes ___ No If yes to #2, #3, or #4, please provide complete details including why license was revoked or the disposition of the charge.

MILITARY HISTORY

1. H ave you ever served In the Armed Forces of the United States? ___ Yes ___ no
Branch of Service:_____ Highest Rank:_____

Active Duty Dates: From:_____ To:_____ From:_____ To:_____

2. Date of discharge:_____

3. Are you now or have you ever been a member of a reserve unit or the National Guard? ___Yes ___No

4. If yes state branch of service, name and location of your unit and whether you attend drills, meetings, or camps:

_____

_____

_____

5. Was any type of disciplinary action taken against you in the service? ___ Yes ___ No
If yes, Date_____ Place_____
Nature of Offense:_____
Action Taken: _____

6. Are you designated as disabled because of military service? ___ Yes ___ No

VETERANS, PREFERENCE: Check the appropriate block if you are claiming veterans' preference.
Documentation substantiating your claim must be furnished at the time of application

___a. A veteran with a service-connected disability who is eligible for or receiving compensation, disability retirement, or pension under public laws administered by U.S. Veteran's Administration or the Department of Defense, or

___b. The spouse of a veteran who cannot qualify for employment because of a total and permanent disability, or the spouse of a veteran missing in action, captured, or forcibly detained by a foreign power, or

___c. A veteran of any war who has served on active duty for 181 consecutive days or more, or who has served 180 consecutive days or more since January 31, 1955 and who was honorably discharged from the Armed Forces of the United States of America if any part of such active duty was performed during a wartime era, excluding active duty for training, or

___d. The unmarried widow of a veteran who died of a service-connected disability.

Have you claimed and been employed using veteran's preference since October 1, 1987? ___Yes ___No

If yes give name of employer: _____

NOTE: Under Florida law, preference in appointment shall be given first to those persons included a. and b. above, and second to those persons included in c. and d. above. If an applicant claiming veteran's preference for a Vacant position is not selected for the vacant position, he/she may file a complaint with the Division of Veterans' Affairs, P.O. Box 1437, St. Petersburg, FL. 33731

PERSONAL REFERENCES & ACQUAINTANCES

Give three (3) references (not relatives, former or present employers, fellow employees or school teachers) who have known you well for the past three (3) years

Complete Name: _____ Years Acq._____ Occupation:_____	Home Address:_____ City & State: _____ Home Phone:_____ Business Address:_____ City & State:_____ Business Phone:_____
Complete Name: _____ Years Acq._____ Occupation:_____	Home Address:_____ City & State:_____ Home Phone:_____ Business Address:_____ City & State:_____ Business Phone:_____
Complete Name: _____ Years Acq._____ Occupation:_____	Home Address:_____ City & State:_____ Home Phone:_____ Business Address:_____ City & State:_____ Business Phone:_____

ORGANIZATION MEMBERSHIP

List all professional, trade business, or civil activities and offices held:

You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status:

_____

_____

_____

_____

APPLICANT'S CERTIFICATION

I understand that my employment will be contingent upon the results of a complete background investigation. I am aware that any omission, falsification, misrepresentation will be the basis for my disqualification as an applicant or my dismissal from the County job. I agree to the conditions and certify that all statements made by me on this application are true, correct and complete, to the best of my knowledge. I further fully understand and consent to a polygraph elimination concerning the veracity of my responses to the information requested on this application or which is discovered as a result of the background investigation, or any physical examination or drug test. I also understand that I may be fingerprinted. I understand that this employment application shall become the property of the County and that it and the information received in response to the background examination are public records.

I further understand and agree that my employment will be contingent upon the results of a completed drug test.

I understand that the use of drugs or alcohol is not permitted, during work or duty time, whether paid or unpaid, in the areas, including vehicles, where work is performed by employees or appointees.

I understand that my continued employment may be contingent upon the results of medical or psychological examinations that I may be required to take during the term of my employment.

I understand and agree that any employment offered to me will be contingent upon my acceptance of compensatory time off, instead of cash, in payment for overtime hours that I work, to the extent allowed by law. I understand, however, that the County has absolute discretion to periodically substitute cash, in whole or part, for my accrued compensatory time.

I understand that unless otherwise defined by applicable law, any employment relationship with the County is "at will", which means that the employer may discharge me at any time with or without cause and that this "at will" relationship may not be changed unless authorized in writing from the County.

I authorize any of the persons or organizations referenced in this application to furnish information, personal or otherwise, regarding my ability and fitness for employment with the County and I relieve all such parties from any and all liability for any damage that might result from furnishing such information to the County.

I agree to conform to the rules, regulations and orders of the County and acknowledge that these rules , regulations and orders may be changed, interpreted, withdrawn or added to by the County, at its discretion, at any time without any prior notice to me.

_____ _____

Signature of the applicant as usually written Date

Witnessed by:

_____

This form must be filled out if you are offered a job!

BOARD OF COUNTY COMMISSIONERS
JEFFERSON COUNTY, FLORIDA
THE KEYSTONE COUNTY-ESTABLISHED 1827
1484 SOUTH JEFFERSON STREET; MONTICELLO, FLORIDA 32344
PHONE: (850)-342-0287

OATH OF LOYALTY

I, _____, a citizen/resident of the State of _____ and of the United States of America, and being employed by an officer of Jefferson County, Florida, and a recipient of public funds as such employee or officer do hereby solemnly swear or affirm that I will support the Constitution of the United States and of the State of Florida.

Signature: _____

Printed Name: _____

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me by means of
☐ physical presence or
☐ online notarization,
this ____ day of _____ 20__, by _____,
☐ who is personally known to me or
☐ who has produced _____ as identification.

_____
Signature of Notary Public

Printed Name of Notary: _____
Commission Number: _____
Commission Expiration: _____

(Notary Stamp)

PERSONAL INQUIRY WAIVER

Authority for release of information

Authority for release of information

To: Concerned Person or
Authorized Representative of
Any Organization, Institution
Or Repository of Records

APPLICANT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NO.: _____

I respectfully request and authorize you to furnish Jefferson County and any and all information that you may have concerning my work record, school record, military record, driving record, reputation, and financial and credit status. (Financial and credit status will only be asked for if you are offered a job that gives you access to cash or the transferring of funds) Please include any and all reports including all information of a confidential or privilege nature, and photostats of same, if requested. This information is to be used to assist in my qualifications and fitness for the position I am seeking with the County.

I hereby release you, your organization or others from any liability or damage which may result from furnishing the information requested above.

_____ _____

Applicant's Signature Date

_____

Address

_____

City State Zip

AFFIDAVIT

STATE OF FLORIDA

COUNTY OF _____

Subscribed and sworn to (or affirmed) before me on _____ (date) by _____

(name of affiant). He/She is personally known to me or has presented _____
(type of identification) as indicated.

(Seal) Signature _____

Name _____ Commission No: _____

Tittle _____ Expires: _____

EMPLOYEE CONSENT TO TEST FOR DRUGS

I consent to submit a urine specimen to test for drugs, including: alcohol, distilled spirits, wine, malt beverages, intoxicating liquors, amphetamines, cannabinoids, cocaine, phencyclidine (PCP), hallucinogens, methaqualone, opiates, barbiturates, benzodiazehines, synthetic narcotics, designer drugs or metabolite of any of the above substances. I release TMH Family Health and the examining doctor (and/or other authorized personnel) from al liability for any damage whatsoever arising from or connected in any way with such tests. I also understand that the outcome of this test determines my future employment and/or job acceptance.

I hereby authorize TMH Family Health or its representative to furnish Jefferson County or its representative the results of such tests and any other relevant medical information they may have. I also release TMH Family Health and its personnel from all liability or damages whatsoever in furnishing such results and information.

I also acknowledge that it is important to disclose the usage of any drugs, whether they are prescribed by a physician or otherwise. I have taken the following drugs or substances within the last two weeks:

___ Sleeping pills

___ Diet pills

___ Pain relief pills

___ Cold tablets

___ Tranquilizers

___ Depression Medications

___ Any other medications or substance (including illicit/illegal drugs)

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND I UNDERSTAND THE CONSEQUENCE OF ANY MISREPRESENTATION OR CONCEALMENT OF INFORMATION.

Signature: _____ Date: _____

Witness: _____

THIS QUESTIONNAIRE MUST BE FILLED OUT COMPLETELY BY ALL EMPLOYEES, PRESENT AND FUTURE, AND MADE PART OF YOUR EMPLOYEE FILE.

Employer Name:	FL Drivers License #:
Applicant Name:	S. S. #:
Height? Weight?	Telephone:
Address:	How long at address?
Previous Address:	Blood type:

Instructions: Any false statements, misrepresentations or concealment to secure employment are sufficient grounds for dismissal.

Answer YES or NO and give the date. Write in other applicable information (dates, details, etc.) in the line provided. DO NOT CHECK BOXES.

****

DO YOU OR HAVE YOU EVER HAD...

1. Epilepsy [ ] _____
2. Diabetes [ ] _____
3. Cardiac disease (heart trouble) [ ] _____
4. Marie-Strumpell Disease [ ] _____
5. Amputation of foot, leg, arm or hand [ ] _____
6. Total loss of sight in one or both eyes [ ] _____
7. Partial loss of corrected vision of more than 75% bilaterally? [ ] _____
8. Residual disability from poliomyelitis [ ] _____
9. Cerebral palsy [ ] _____
10. Multiple sclerosis [ ] _____
11. Parkinson's disease [ ] _____
12. Vascular disorder [ ] _____
13. Psychoneurotic disability following treatment in recognized medical/mental health institution for a period in excess of six months [ ] _____
14. Hemophilia [ ] _____
15. Chronic osteomyelitis [ ] _____
16. Ankylosis of a major weight bearing joint [ ] _____
17. Hypoglycemia [ ] _____
18. Muscular dystrophy [ ] _____
19. Thrombophlebitis [ ] _____
20. Herniated intervertebral disc [ ] _____
21. Surgical removal of an intervertebral disc or spinal fusion [ ] _____
22. Total deafness [ ] _____
23. Mental retardation [ ] _____

24. Any permanent physical condition which constitutes a 20% impairment to the body as a whole? [ ] _____
25. Rheumatic fever [ ] _____
26. High blood pressure [ ] _____
27. Varicose veins or leg ulcer [ ] _____
28. Chest pain [ ] _____
29. Tuberculosis [ ] _____
30. Allergies [ ] _____
31. Hay fever or asthma [ ] _____
32. Skin disorder or problems [ ] _____
33. Allergy/reaction to serum or drug [ ] _____
34. Kidney or bladder problems [ ] _____
35. Ulcers [ ] _____
36. Head injury [ ] _____
37. Cancer [ ] _____
38. Dizziness or fainting spells [ ] _____
39. Arthritis or rheumatism [ ] _____
40. Knee injury [ ] _____
41. Are you unable to perform certain body motions assume certain body positions? [ ] If so, please describe. _____
42. Have you ever been ruptured? [ ] If so, which side? Was it operated? When? _____
43. Do you wear glasses or contact lenses? [ ] If so, do you wear the lenses all the time, occasionally or for reading only? _____
44. Have you ever had an injury to your back or neck? [ ] If so, please explain when and how: _____
45. Have you ever had a state claim for industrial injury? [ ] If so, is the claim now open? [ ] Please provide the date, reason and employer: _____
46. Have you ever had any operations or do you now have any disability not covered by the above questions? [ ] Please explain: _____
47. Date of last physical examination / name of physician: _____

I, _____, acknowledge that all statements and information given in this application are true to the best of my knowledge and belief.

Signature of applicant: _____ Date: _____

Witness: _____ Date: _____

EMPLOYEES MAY BE REQUIRED TO TAKE A PHYSICAL EXAMINATION BEFORE BEING ACCEPTED FOR EMPLOYMENT. IS A PHYSICAL EXAMINATION REQUIRED? YES NO

[please attach a voided personal check here]

Jefferson County, Florida
Direct Deposit Authorization

Social Security Number: _____

Full Name: _____

Home Mailing Address: _____

_____

Work Telephone: _____

Other Telephone: _____

Direct Deposit Action Requested (circle one): start / change / name change / delete

Financial Institution/Bank: _____

Account Type (circle only one): checking / savings

Your Bank Account Number: _____

Transit Routing Number of Your Financial Institution: _____

Signature: _____ Date: _____

This form must be signed and dated by employee. The above signature signifies acceptance of the terms and conditions of the below agreement. This form will start, change or stop direct deposit for all payments received by you from Jefferson County, Florida. Please be advised that "transit routing number" refers to the nine-digit number that identifies your financial institution. It is found in the bottom left corner of your personal check.

Agreement: I hereby authorize and request Jefferson County, Florida to initiate credit entries and, if necessary, a debit entry in accordance with NACHA rules reversing a credit entry made in error, to my account at the financial institution named above. This direct deposit will remain in effect until withdrawn by: a) me, in writing with time to effect termination; b) my death or legal incapacity; c) the financial institution; or (d) Jefferson County, Florida. It will purge approximately six months after my last wage. Note: Please make sure your direct deposit has stopped before closing your account. Otherwise, the funds will be returned to the payer and delay you from receiving your payment.

Please return to: H.R. Dept.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c).** The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents".)

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

FRS
Florida Retirement System

FRS Employment Certification Form

This form is not an offer of employment and completion of this form does not constitute enrollment in a retirement program under the Florida Retirement System (FRS). If you are hired, information about your retirement plan options may be mailed to your address on file.

1 Enter Your Info

PLEASE PRINT

NAME _____ SOCIAL SECURITY NUMBER _____

CURRENT AGENCY NAME _____ PREVIOUS AGENCY NAME _____

2 Confirm Prior Membership

Have you ever been a member of a State of Florida-administered retirement plan?

☐ **No, I have never been a member of a State of Florida-administered retirement plan.**
If No, skip to section 4.

☐ **Yes, I have been a member of a State of Florida-administered retirement plan.**
If Yes, indicate which plan(s) you are or were a member of, then proceed to section 3.

- ☐ FRS Pension Plan (including DROP)
- ☐ FRS Investment Plan
- ☐ Senior Management Service Optional Annuity Program (SMSOAP)
- ☐ State Community College System Optional Retirement Program (SCCSORP)
- ☐ State University System Optional Retirement Program (SUSORP)
- ☐ Other _____

3 Confirm Retiree Status

Are you retired from a State of Florida-administered plan? You are considered retired if:

- You have received any benefits (other than a withdrawal of your employee contributions) under the FRS Pension Plan, including DROP.
- You have taken any distribution (including a rollover) from the FRS Investment Plan, or other state-administered retirement programs offered by state universities (SUSORP), state community colleges (SCCSORP), state government for senior managers (SMSOAP), or local governments for senior managers.

☐ **No, I am not retired from a State of Florida-administered plan.** I understand that if it is later determined I am retired, both my employer and I might be liable for repaying retirement benefits I have received if I am reemployed by or provide services to an FRS-covered employer through any paid or unpaid arrangement as described below. Refer to Page 2 for additional information.

☐ **Yes, I am retired from a State of Florida-administered plan, and I understand I must satisfy any termination requirement prior to returning to FRS employment.**
If Yes, enter your FRS Pension Plan retirement effective date, DROP termination date, or date you received your first distribution from the FRS Investment Plan, SUSORP, SCCSORP, SMSOAP, or other plan.

DATE _____

4 Sign Here

By signing below, I acknowledge that I have read and understand the information on pages 1 and 2 of this form, and I certify all supplied information to be true and correct.

SIGNATURE _____ DATE _____

Questions? Call the MyFRS Financial Guidance Line at 1-866-446-9377, Option 2 (TRS 711) or visit MyFRS.com.

This completed form, including page 2, should be retained in the employee's personnel file. Do not send this form to the FRS, unless requested.

Review the Following Important Information Carefully

- If you are a Pension Plan retiree, you understand:
  - If you are reemployed within six calendar months of retirement in **any type of position** with an FRS-participating employer, your retirement and DROP status (if applicable) are voided, all retirement and DROP benefits you received must be repaid, and you must reapply for retirement to receive future benefits.
  - If you are reemployed during months 7 through 12 after retirement in **any type of position** with an FRS-participating employer, your monthly retirement benefit must be suspended and any overpaid benefits you received must be repaid.
- If you are an Investment Plan SUSORP, SCCSORP, or SMSOAP retiree, you understand:
  - If you are reemployed within six calendar months of retirement in **any type of position** with an FRS-participating employer, any benefits you received must be repaid, or you must terminate employment.
  - If you are reemployed during months 7 through 12 after retirement in **any type of position** with an FRS-participating employer, you will not be eligible for additional distributions until you terminate employment or complete 12 calendar months of retirement (whichever occurs first).
- **Any type of position** includes, but is not limited to, regularly established, full-time, part-time, OPS, temporary, seasonal, substitute teachers, adjunct professors, etc. Also, any paid or unpaid positions with an FRS employer, service arrangements with an FRS employer, employment by or through a third-party providing service to an FRS employer, or positions pre-arranged before retirement to provide services after retirement to any FRS employer, are prohibited.
- Florida law requires a return of all overpaid Pension Plan benefit payments or Investment Plan distributions received by a member who has violated the FRS termination or reemployment provisions. Similar provisions apply to overpaid SUSORP, SCCSORP, or other state-administered plan distributions – contact that plan's administrator for details.
- There is one exception to the restrictions on reemployment limitations after retirement. If you are a retired law enforcement officer and are reemployed as a school resource officer by an FRS-covered employer during the seventh through twelfth calendar months after your retirement date or after your DROP termination date, you are eligible to receive both your salary and retirement benefits during this period.
- Effective July 1, 2017, retirees of the Investment Plan, SUSORP, SMSOAP, SCCSORP are eligible for renewed membership in the Investment Plan, SUSORP, SMSOAP, SCCSORP. You must be employed in an FRS-covered position on or after July 1, 2017 in order to have renewed membership. Renewed members may not use a second election to change to the Pension Plan.
- If you are not retired and you earned FRS service after certain periods since 2002 (depending on your employer), you will be enrolled in the FRS retirement plan you were enrolled in when you terminated FRS-covered employment.

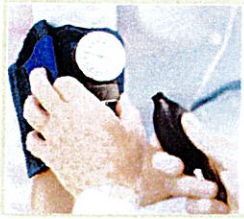
This completed form, including page 2, should be retained in the employee's personnel file. Do not send this form to the FRS, unless requested.

Jefferson County

2023 Benefits at a Glance

Active Employees

October 1, 2023-September 30, 2024



MEDICAL INSURANCE BASICS

Choosing your health care plan can be confusing. To help you make an informed health plan selection, the basics of your health care options are listed on the following pages. Below please find basic information to get you started.

PROVIDER DIRECTORIES: Capital Health Provider Directories can be found on-line at www.capitalhealth.com. You have the option of a quick search in which you can search for a provider by name, area of speciality or location. Additionally, you can perform an advanced search of the provider directory utilizing specific criteria, such as office hours, board certifications or whether they are accepting new patients or not. You may also print a provider directory from the website by plan, by region or you can custom design your own provider directory. There are very easy step-by-step instructions provided. If you would prefer, you can also order a provider directory by calling the customer service telephone number listed on the back of your ID card.

THE BASICS: Most health plans today have a plan design that includes a combination of copayments, coinsurance and deductibles, resulting in the sharing of costs for services for those individuals enrolled in the plan.

- ⇒ **Copayment**: A copayment is a pre-determined amount members must pay out of pocket when seeing a participating provider. It is paid directly to the provider and is due at the time services are rendered. If you are unsure of what you need to pay for a particular service, you can call customer service at the toll-free telephone number listed on the back of your ID card.
- ⇒ **Deductible**: A deductible is an agreed-upon amount that must be paid out of pocket by you when receiving care from a provider *before* your insurance carrier will pay for any services (excludes copayments).
- ⇒ **Coinsurance**: Coinsurance is a percentage that designates the portion the insurer and you are responsible to pay when services are obtained. Please be reminded that any deductible amount must be paid before coinsurance will apply.
- ⇒ **Precertification**: Certain services such as hospitalization or outpatient surgery may require prior authorization with Captial Health Providers to verify coverage for those services. Your participating physician should obtain this precertification for you prior to your treatment. You can contact customer service to learn whether your plan requires precertification.

SERVICE AREA:

Your service area is limited to the following counties: Calhoun, Franklin, Leon, Liberty, Gadsden, Jefferson, and Wakulla. If you have any questions about your service area, please contact member services at (850) 383-3311 or (877) 247-6512.

MEDICAL INSURANCE

Capital Health - Active Employees

Coverage	Semi-Monthly Cost
Employee	$ 0.00
Employee & Spouse	$ 154.21
Employee & Child(ren)	$ 105.97
Family	$ 250.00

HEALTHCARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum:	Unlimited	Not Applicable
Annual Out-of-Pocket Maximum: Individual Family (Excludes Pharmacy Copays)	Medical $2,000 $4,500	Not Applicable
Calendar Year Deductibles: Individual Family	 $0 $0	Not Applicable
Coinsurance Percentage Paid by Plan:	100%	Not Applicable
Preventive Care: Routine Adult & Child Wellness Services Immunizations Mammogram Colonoscopy *age and frequency schedule applies	100% Covered	Not Applicable
Physician Services: Primary Care Physician Office Visits Specialist (referral required) Chiropractic (referral required) Telehealth (primary/specialist)	 $15 Copay $25 Copay $25 Copay $15 / $25 Copay	Not Applicable
Hospital Services: Inpatient Hospitalization Outpatient Surgical Services Ambulatory Surgical Center Emergency Room Urgent Care Facility Medically Necessary Ambulance Service	 $250 Copay $150 Copay $100 Copay $300 Copay $20 Copay $100 Copay	 Not Applicable Not Applicable Not Applicable $300 Copay $20 Copay $100 Copay
Diagnostic Services: Diagnostics - Lab & X-Ray Major Diagnostics - CT Scans, MRI, Pet Scans	 $0 $100 Copay	Not Applicable
Mental Health Services: Inpatient Care Outpatient	 $250 Copay $25 Copay	Not Applicable
Pharmacy: (30day Supply) **Pharmacy Out-of-Pocket-Maximum** Tier 1 - Generic Prescriptions Tier 2 - Preferred Brand Name Prescriptions Tier 3 - Non-Preferred Brand Name Prescriptions Tier 4 - Specialty Drugs	 **$4,600 ($8,700 Family)** $15 Copay $30 Copay $50 Copay $50 Copay	Not Covered

This Benefits at a Glance handbook is designed to provide basic information to employees on employee benefit plans and programs available October 1, 2023—September 30, 2024 at Jefferson County. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute a SPD or Plan Document as defined by the Employee Retirement Income Security Act

Capital Health PLAN **Premier Plus Selection $15/$30/$50** **Coverage for:** Employee or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.capitalhealth.com/sbc. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $2,000 single coverage / $4,500 family coverage. Pharmacy: $4,600 single coverage $8,700 family coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Specialist visit	Office: $25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://capitalhealth.com/members/about-your-	Tier 1-Preferred Generic Tier 2-Non-Preferred Generic	$15/30-day supply	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
	Tier 3- Preferred Brand	$30/30-day supply	Not Covered	
	Tier 4-Non-Preferred Brand drugs	$50/30-day supply	Not Covered	Prior authorization and/or quantity limits may

medications				apply. Your benefits/services may be denied.
	Specialty drugs Tier 5-Preferred Specialty Tier 6-Non-Preferred Specialty	$50 /30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $100 / visit Hospital: $150 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$25 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$300 / visit $150 / observation	$300 / visit $150 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $20 / visit Telehealth: $20 / visit Amwell: $15 / visit	Urgent care center: $20 / visit Telehealth: $20 / visit Amwell: $15 / visit	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission $150 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted $25 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	$25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.

	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$25 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Annual routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 850-383-3311, 1-877-247-6512.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other copayment	$50

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

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Step 2: Enter Service Key **CHP**
Step 3: Select the doctor you'd like to see

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capitalhealth.com/amwell

Raymond Sanders
Member Services Specialist

Questions?
850.383.3311 or 1.877.247.6512
8:00am - 5:00pm, Monday - Friday

Medicare members, please call:
850.523.7441 or 1.877.247.6512

October 1 - March 31:
8:00am-8:00pm, seven days a week

April 1 - September 30:
8:00am-8:00pm, Monday-Friday

TTY 850.383.3534 or 1.877.870.8943

State of Florida members, please call:
1.877.392.1532, 7:00am-8:00pm, Monday - Friday

Capital Health PLAN

CHP USE ONLY:	Effective Date:
ID#:	Group #:

ENROLLMENT APPLICATION

Applying for New Membership: ☐ Transferring Present Membership: ☐ OR Re-Enrolling: ☐ ID#:

Type of Coverage Applying For: ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family

1. Last Name:	**2. First Name:**	**3. M.I.:**
4. Name of Employer:	**5. Hire Date:**	**6. Type of Employment:** ☐ Full-Time ☐ Part-Time: _______ Hours per week

7. I do not wish to apply for CHP Coverage/Membership. I understand that, if I decide to apply at a later time, Coverage/Membership may not be available until the next open enrollment period, or I may be asked to provide evidence of insurability. **IF YOU DECLINE COVERAGE, PLEASE DO NOT COMPLETE THE REST OF THIS FORM.**

Signature of Applicant/Employee: **Date:**

8. Physical Street Address:

Street City State Zip Code County

9. Mailing Address:
(If different from above)

Street City State Zip Code County

10. DOB:	**11. SSN:**	**12. Sex:** ☐ Female ☐ Male	**13. Marital Status:** ☐ Married ☐ Single ☐ Legally Separated ☐ Widowed ☐ Divorced	**14. Work Phone #:**	**15. Home Phone #:**

16. LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED PLEASE PRINT
A certified copy of the court order must be attached for dependents in court-ordered custody or guardianship of the certificate holder. If more space is required, attach a separate page with additional information.
Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.

17. Applicant's Primary Care Physician Selection:

Current Patient? ☐ Yes ☐ No

18. Relationship To You		19. First Name & Middle Initial Last Name (if not the same)	20. Social Security Number	21. Date of Birth	22. Supported By You	Living with You	Full-Time/ Part-Time Student	Disabled	23. Primary Care Physician	Current Patient?
Spouse	☐ Male ☐ Female							☐ Yes ☐ No		☐ Yes ☐ No
☐ My Child ☐ Stepchild ☐ Other 🗐	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
☐ My Child ☐ Stepchild ☐ Other 🗐	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
☐ My Child ☐ Stepchild ☐ Other 🗐	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No

🗐 Supporting documentation required.
Are you or any member of your family covered by any other health plan or health insurance? ☐ Yes ☐ No
If yes, complete the appropriate section(s) below. If more space is needed, attach a separate sheet with additional information.
***Note**: If you or your dependents currently have coverage, or had any coverage within the past 63 days that this coverage replaces, please fill out and attach a Prior/Concurrent Option Coverage Affidavit form, or attach a Certificate of Creditable Coverage.*

24. OTHER HEALTH PLAN INSURANCE		25. MEDICARE	
Insured Member's Name: **Date of Birth:**		**Beneficiary Name:**	**Beneficiary Name:**
Employment Status: ☐ Active ☐ Retired **Type of coverage:** ☐ Single ☐ Family	**Name of Employer:** ____________	**Entitlement Reason:** ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability	**Entitlement Reason:** ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability
Policy #:	**Effective Date:**	**Medicare #:**	**Medicare #:**
Name of Insurance Company:	**Phone:**	**Part A Effective Date:**	**Part A Effective Date:**
Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No **If no**, please list dependents not covered on a separate sheet.		**Part B Effective Date:**	**Part B Effective Date:**

ACCEPTANCE OF COVERAGE/MEMBERSHIP: I have read and understand the Acceptance of Any Coverage/Membership on the reverse side of this form.

Signature of Applicant/Employee: Date:

Employer Representative Signature: Date: Applicant's Proposed Coverage Effective Date:

ACCEPTANCE OF ANY COVERAGE/MEMBERSHIP –
READ BEFORE SIGNING ON THE FRONT OF THIS FORM

I hereby apply for the coverage/membership selected on the front side of this form. My employer has selected the coverage/membership through Capital Health Plan, Inc., d/b/a/ Capital Health Plan (CHP). I authorize my employer to deduct from my earnings my premium contribution, if any. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all of the requirements of the group contract.
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all of the requirements of the group contract.
3. If I must pay part or all of the premium, coverage/membership shall not become effective until CHP accepts this application and assigns an effective date.

I agree that any controversy or dispute between CHP and myself or my dependents shall be subject to the complaint and grievance procedures, including binding arbitration, set forth in the CHP Member Handbook.

I understand that my employer is not an agent of CHP. I also understand that my employer is responsible for notifying employees of all: 1) effective dates; 2) termination dates; 3) conversion, COBRA, or ERISA rights and responsibilities; and, 4) other matters pertaining to coverage/membership under the group contract.

I authorize persons or entities that have any medical or other records or knowledge of me or my eligible dependents to release that information to CHP. These persons or entities include any: 1) licensed physician; 2) medical practitioner; 3) hospital; 4) clinic or other medical or medically related provider; 5) insurer; 6) employer; or, 7) other organization, institution, or person. This information also may be released to any affiliated or reinsurance carrier. I also authorize CHP, at its sole discretion and consistent with law, to use and disclose financial and health information obtained about me and/or my eligible family members for treatment, payment, and/or health care operations purposes, including coordination of benefits, if needed. This routine consent covers future, known, or routine needs for personal health information. These routine needs include treatment, coordination of care, quality measurement, including surveys of members, accreditation, and billing. These releases specifically include, but are not limited to, authorization to release: 1) any and all medical records; and, 2) information about, associated with, or with reference to certain conditions. This information consists of specific medical information on me or my dependents, including, but not limited to, authorization to release: 1) any and all medical records; and, 2) information about certain conditions. These conditions include: 1) exposure to HIV infection; 2) ARC; 3) alcohol or drug dependency; and, 4) mental and nervous disorders. I understand that CHP shares no member-identifiable information with employers unless the member provides specific consent.

When an overpayment is made, I authorize CHP to recover the excess from any person or entity that received it.

I acknowledge that, if I apply for CHP coverage/membership at a later date, coverage/membership may not be available until the next open enrollment. Also, I may be required to furnish evidence of insurability.

I acknowledge that CHP coverage/membership is contingent on the complete, accurate disclosure of the information requested on this form. I represent that the statements on this application are true and complete. I understand and agree that any misstatements or omissions may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the terms and conditions of the group contract. I understand that this application is part of the group contract.

DEPENDENT'S ALTERNATE ADDRESS INFORMATION:

NAME	ALTERNATE ADDRESS

FRAUD WARNING

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.

DENTAL INSURANCE

The Standard

Coverage	Semi-Monthly Cost
Employee	$ 21.00
Employee & Spouse	$ 44.16
Employee & Child(ren)	$ 49.04
Family	$ 66.74

Jefferson County provides the opportunity for all eligible employees to purchase dental insurance through The Standard.

The Standard Dental Plan provides you and your family dental benefits through both participating and non-participating dental providers. Should you choose to see a non-network provider, you may be balance billed the difference between the amount that provider retails for their services and the usual / customary rate. Listed below is a brief summary of some of the dental services covered under the dental plan and their applicable coinsurance coverage level.

Dental Services:	PPO In-Network	Non PPO Out-of-Network
Calendar Year Deductible: (Waived for Preventive Services)	$50 ($150 Family)	$50 ($150 Family)
Calendar Year Plan Maximum: (Combined in and out of network)	$1,000	
Increased Dental Maximum: A portion of each member's unused annual plan maximum can be rolled over into next year's Plan Year Maximum, to be used in future years if a member reaches the Calendar Year Plan Maximum. To qualify, a member must submit a claim and also cannot exceed the annual claims threshold during the benefit year.		
Annual Claims Threshold:	$500	$500
Carry Over Amount per Benefit Period:	$250	$250
PPO Bonus per Benefit Period:	$100	N/A
Maximum Rollover Account Limit:	$1,000	$1,000
Preventative Services: Routine Exams Cleaning (prophylaxis) X-Rays Fluoride Treatment	100% Covered Deductible Waived	100% of U&C Deductible Waived
Basic Services: Sealants Amalgam Fillings Resin Fillings Root Canal Therapy Repairs of dentures Oral Surgery	80% Covered	80% of U&C After deductible
Major Services: Space Maintainers Inlays Onlays Crowns Dentures	50% Covered	50% of U&C After Deductible

*U&C=Usual and Customary Rate, U&C based on the 90th percentile

JEFFERSON COUNTY BOARD OF COMMISSIONERS
Dental Highlight Sheet

TheStandard®
Positively different.

Plan 1: Dental Plan Summary **10/01/2021**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	3 Family Maximum
Maximum *(per person)*	$1,000 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK Assist℠	None
Annual Open Enrollment	Included

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Sealants (age 13 and under)	• Space Maintainers
• Bitewing X-rays (1 in 12 months)	• Restorative Amalgams	• Onlays
• Full Mouth/Panoramic X-rays (1 in 5 years)	• Restorative Composites	• Crowns (1 in 10 years per tooth)
• Periapical X-rays	• Endodontics (nonsurgical)	• Crown Repair
• Cleaning (1 in 6 months)	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
• Fluoride for Children 13 and under (1 in 12 months)	• Periodontics (nonsurgical)	• Complex Extractions
	• Periodontics (surgical)	• Anesthesia
	• Denture Repair	
	• Simple Extractions	

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

JEFFERSON COUNTY BOARD OF COMMISSIONERS
Dental Highlight Sheet

TheStandard®
Positively different.

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose the network found on your ID Card.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

JEFFERSON COUNTY BOARD OF COMMISSIONERS
Dental Highlight Sheet

TheStandard®
Positively different.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance.

Your Full Name

Dental Insurance

☐ Dental (Employee paid)

Are you or your dependents covered for dental insurance under another plan? ☐ Yes ☐ No

Dental Insurance is administered by Ameritas Life Insurance Corp.

List dependents to enroll or drop for Dental, if applicable. (Attach sheet for additional dependents, if needed.)

Full Name (Last name if different, First, Middle Initial)	Dental (Employee paid)		Gender		Date of Birth
	Add	Drop	M	F	
Spouse	☐	☐	☐	☐	
Child 1	☐	☐	☐	☐	
Child 2	☐	☐	☐	☐	
Child 3	☐	☐	☐	☐	

Dental Insurance Waiver: Contributory Dental 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 Entrant Penalty.

I decline ☐ Dental insurance for myself.

I decline ☐ Dental insurance for one or more dependents.

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance, if any, available through your Employer. Unless specified otherwise on a separate sheet of paper, this designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*
Contingent — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*

*Total must equal 100%

Your Full Name

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. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Signature of Applicant (Member/Employee)	Date

LIFE INSURANCE
The Standard

Basic Term Life and AD&D Insurance

Employer Paid Term Life: Jefferson County provides group term life insurance and accidental death and dismemberment coverage through The Standard to all full-time employees. All eligible employees are provided with term life insurance in the amount of **$25,000**. **The cost of this insurance is paid entirely by Jefferson County**.

Accidental Death & Dismemberment:
This benefit is the principal sum amount equal to the amount of your life insurance benefit amount.

Conversion:
When your employment ends, you may apply for an individual life insurance policy from The Standard. You will be responsible for the premium for the coverage. Please see your Human Resources Department for more information.

Accelerated Living Benefit:
This benefit feature is standard with term life coverage and is available to you exclusively. This benefit allows you to apply for payment of some of your life insurance should a licensed physician diagnose you as having a terminal health condition. You may receive portion of the amount of the life insurance benefit. Please see your human resources department for more information.

Eligibility: All Eligible Employees.

Schedule of Benefits: **$25,000** benefit limit

Age Reduction Schedule: 35% reduction at 65; 50% reduction at 70; 35% reduction at 75

Voluntary Term Life and Insurance

With Voluntary Term Life Insurance, you are able to purchase high amounts of coverage at a low cost through The Standard. Premium amounts are conveniently withheld as a payroll deduction. You also have the option of purchasing term life insurance for your dependents as well.

You may purchase term life insurance coverage for yourself in increments of $10,000 up to a maximum of $300,000. However, you may not purchase an amount in excess of five times your annual salary. For example, if your annual earnings equal $20,000, you may not purchase in excess of $100,000 of term life insurance. You may also purchase up to $150,000 of term life for your spouse in $5,000 increments. However, the coverage for your spouse is limited to one-half of the amount of term life you have purchased for yourself. Using the above example, the spouse would be limited to $50,000 in term life insurance. Your can purchase term life insurance for your dependent children (to age 20 or 24 if full-time student) in $2,000 increments up to a maximum of $10,000 for a payroll deduction of $0.20 per $2,000.

If you are a new employee, you can purchase up to $50,000 of term life insurance without having in answer any medical questions. You can purchase up to $10,000 of term life insurance on your spouse without them having to answer a medical questionnaire. Children are guaranteed up to the maximum $10,000. If you are not currently enrolled and would like to purchase term life insurance, you need to fill out a medical questionnaire regardless of the amount being purchased.
Please see the next page for rates and semi-monthly premiums.

LIFE INSURANCE

Semi-Monthly Premiums

Age Band / Rate	< 30 0.11	30—34 0.12	35—39 0.16	40—44 0.24	45—49 0.38	50—54 0.59	55—59 1.03	60—64 1.15	65—69 1.95	70—74 3.47	75+ 13.16
$10,000	$0.55	$0.60	$0.80	$1.20	$1.90	$2.95	$5.15	$5.75	$6.34	$8.68	$23.03
$20,000	$1.10	$1.20	$1.60	$2.40	$3.80	$5.90	$10.30	$11.50	$12.68	$17.35	$46.06
$30,000	$1.65	$1.80	$2.40	$3.60	$5.70	$8.85	$15.45	$17.25	$19.01	$26.03	$69.09
$40,000	$2.20	$2.40	$3.20	$4.80	$7.60	$11.80	$20.60	$23.00	$25.35	$34.70	$92.12
$50,000	$2.75	$3.00	$4.00	$6.00	$9.50	$14.75	$25.75	$28.75	$31.69	$43.38	$115.15
$60,000	$3.30	$3.60	$4.80	$7.20	$11.40	$17.70	$30.90	$34.50	$38.03	$52.05	$138.18
$70,000	$3.85	$4.20	$5.60	$8.40	$13.30	$20.65	$36.05	$40.25	$44.36	$60.73	$161.21
$80,000	$4.40	$4.80	$6.40	$9.60	$15.20	$23.60	$41.20	$46.00	$50.70	$69.40	$184.24
$90,000	$4.95	$5.40	$7.20	$10.80	$17.10	$26.55	$46.35	$51.75	$57.04	$78.08	$207.27
$100,000	$5.50	$6.00	$8.00	$12.00	$19.00	$29.50	$51.50	$57.50	$63.38	$86.75	$230.30
$75,000	$4.13	$4.50	$6.00	$9.00	$14.25	$22.13	$38.63	$43.13	$47.53	$65.07	$172.73
$85,000	$4.68	$5.10	$6.80	$10.20	$16.15	$25.08	$43.78	$48.88	$53.87	$73.74	$195.76
$95,000	$5.23	$5.70	$7.60	$11.40	$18.05	$28.03	$48.93	$54.63	$60.21	$82.42	$218.79
$105,000	$5.78	$6.30	$8.40	$12.60	$19.95	$30.98	$54.08	$60.38	$66.55	$91.09	$241.82
$115,000	$6.33	$6.90	$9.20	$13.80	$21.85	$33.93	$59.23	$66.13	$72.88	$99.77	$264.85
$125,000	$6.88	$7.50	$10.00	$15.00	$23.75	$36.88	$64.38	$71.88	$79.22	$108.44	$287.88
$135,000	$7.43	$8.10	$10.80	$16.20	$25.65	$39.83	$69.53	$77.63	$85.56	$117.12	$310.91
$145,000	$7.98	$8.70	$11.60	$17.40	$27.55	$42.78	$74.68	$83.38	$91.90	$125.79	$333.94
$150,000	$8.25	$9.00	$12.00	$18.00	$28.50	$44.25	$77.25	$86.25	$95.06	$130.13	$345.45
$200,000	$11.00	$12.00	$16.00	$24.00	$38.00	$59.00	$103.00	$115.00	$126.75	$173.50	$460.60
$210,000	$11.55	$12.60	$16.80	$25.20	$39.90	$61.95	$108.15	$120.75	$133.09	$182.18	$483.63
$220,000	$12.10	$13.20	$17.60	$26.40	$41.80	$64.90	$113.30	$126.50	$139.43	$190.85	$506.66
$230,000	$12.65	$13.80	$18.40	$27.60	$43.70	$67.85	$118.45	$132.25	$145.76	$199.53	$529.69
$240,000	$13.20	$14.40	$19.20	$28.80	$45.60	$70.80	$123.60	$138.00	$152.10	$208.20	$552.72
$250,000	$13.75	$15.00	$20.00	$30.00	$47.50	$73.75	$128.75	$143.75	$158.44	$216.88	$575.75
$260,000	$14.30	$15.60	$20.80	$31.20	$49.40	$76.70	$133.90	$149.50	$164.78	$225.55	$598.78
$270,000	$14.85	$16.20	$21.60	$32.40	$51.30	$79.65	$139.05	$155.25	$171.11	$234.23	$621.81
$280,000	$15.40	$16.80	$22.40	$33.60	$53.20	$82.60	$144.20	$161.00	$177.45	$242.90	$644.84
$290,000	$15.95	$17.40	$23.20	$34.80	$55.10	$85.55	$149.35	$166.75	$183.79	$251.58	$667.87
$300,000	$16.50	$18.00	$24.00	$36.00	$57.00	$88.50	$154.50	$172.50	$190.13	$260.25	$690.90

Employee Semi-Monthly Premiums

Spouse Semi-Monthly Premiums

***Please note, that the monthly premiums for the spouse that are not listed in the table above, can be found in the Employee monthly premium chart above.**

Age Band / Rate	< 30 0.11	30—34 0.12	35—39 0.16	40—44 0.24	45—49 0.38	50—54 0.59	55—59 1.03	60—64 1.15	65—69 1.95	70—74 3.47	75+ 13.16
$5,000	$0.28	$0.30	$0.40	$0.60	$0.95	$1.48	$2.58	$2.88	$3.17	$4.34	$11.52
$10,000	$0.55	$0.60	$0.80	$1.20	$1.90	$2.95	$5.15	$5.75	$6.34	$8.68	$23.03
$15,000	$0.83	$0.90	$1.20	$1.80	$2.85	$4.43	$7.73	$8.63	$9.51	$13.01	$34.55
$20,000	$1.10	$1.20	$1.60	$2.40	$3.80	$5.90	$10.30	$11.50	$19.50	$17.35	$46.06
$25,000	$1.38	$1.50	$2.00	$3.00	$4.75	$7.38	$12.88	$14.38	$15.84	$21.69	$57.58
$30,000	$1.65	$1.80	$2.40	$3.60	$5.70	$8.85	$15.45	$17.25	$19.01	$26.03	$69.09
$35,000	$1.93	$2.10	$2.80	$4.20	$6.65	$10.33	$18.03	$20.13	$22.18	$30.36	$80.61
$45,000	$2.48	$2.70	$3.60	$5.40	$8.55	$13.28	$23.18	$25.88	$28.52	$39.04	$103.64
$55,000	$3.03	$3.30	$4.40	$6.60	$10.45	$16.23	$28.33	$31.63	$34.86	$47.71	$126.67
$65,000	$3.58	$3.90	$5.20	$7.80	$12.35	$19.18	$33.48	$37.38	$41.19	$56.39	$149.70
$75,000	$4.13	$4.50	$6.00	$9.00	$14.25	$22.13	$38.63	$43.13	$47.53	$65.06	$172.73
$85,000	$4.68	$5.10	$6.80	$10.20	$16.15	$25.08	$43.78	$48.88	$53.87	$73.74	$195.76
$95,000	$5.23	$5.70	$7.60	$11.40	$18.05	$28.03	$48.93	$54.63	$60.21	$82.41	$218.79
$105,000	$5.78	$6.30	$8.40	$12.60	$19.95	$30.98	$54.08	$60.38	$66.54	$91.09	$241.82
$115,000	$6.33	$6.90	$9.20	$13.80	$21.85	$33.93	$59.23	$66.13	$72.88	$99.76	$264.85
$125,000	$6.88	$7.50	$10.00	$15.00	$23.75	$36.88	$64.38	$71.88	$79.22	$108.44	$287.88
$135,000	$7.43	$8.10	$10.80	$16.20	$25.65	$39.83	$69.53	$77.63	$85.56	$117.11	$310.91
$145,000	$7.98	$8.70	$11.60	$17.40	$27.55	$42.78	$74.68	$83.38	$91.89	$125.79	$333.94
$150,000	$8.25	$9.00	$12.00	$18.00	$28.50	$44.25	$77.25	$86.25	$95.06	$130.13	$345.45

TheStandard®

Benefits at a Glance for Jefferson County Board of County Commissioners

Group Policy # 143638
Effective Date October 1, 2007

Group Basic Life and Accidental Death and Dismemberment Insurance

Basic Life Insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible employee's covered death. Basic Accidental Death and Dismemberment (AD&D) Insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Jefferson County Board of County Commissioners.

Eligibility

Eligible Employee
A regular employee of Jefferson County Board of County Commissioners working at least 32 hours each week. An eligible employee does not include a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.

Waiting Period Before Becoming Eligible for Insurance
None for those that meet the definition of an eligible employee on the group policy effective date. All other employees become eligible on the first day of the month that follows or coincides with their date of hire.

Benefits

Employee Coverage Amount
The Basic Life coverage amount is $25,000.

AD&D Insurance
For accidental loss of life, the amount of this insurance benefit is equal to the employee Basic Life coverage amount. For other covered losses, the amount of this benefit is a percentage of the Basic Life coverage amount.

Age Reductions
Under this policy, insurance coverage reduces by 35 percent at age 65, by 50 percent at age 70, and by 65 percent at age 75.

Other Life Features & Services

- Accelerated Benefit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Jefferson County Board of County Commissioners. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and Jefferson County Board of County Commissioners may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for employees who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

KEY CONTACT INFORMATION

COMPANY NAME	CUSTOMER SERVICE TELEPHONE NUMBER	WEBSITE ADDRESS
Capital Health PLAN Medical Plans	850-383-3311	www.capitalhealth.com
TheStandard Dental PPO and Life Insurance	800-247-6888	www.standard.com
amwell Telehealth	855-818-3627	www.chp.amwell.com

Standard Insurance Company

Enrollment and Change
Florida

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
143638			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

☐ Beneficiary Change ***Complete Beneficiary Section***

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Jefferson County Board of County Commissioners**	Hours Worked Per Week		
Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			
Spouse Full Name		Birth Date	

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Life Insurance

☑ Basic Life with AD&D (Employer Paid)

You must choose one of the following options:

☐ Additional Life (Employee Paid) requested amount $_____

☐ Decline Additional Life (Employee Paid)

Dependents Life Insurance

You must choose one of the following options for your Spouse:

☐ Spouse Life (Employee Paid) requested amount $_____

☐ Decline Spouse Life (Employee Paid)

You must choose one of the following options for your Child(ren):

☐ Child(ren) Life (Employee Paid) requested amount $_____

☐ Decline Child(ren) Life (Employee Paid)

Your Full Name

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

BOARD OF COUNTY COMMISSIONERS
JEFFERSON COUNTY, FLORIDA
Annual Information Update

Employee Name: _____

DOB: _____

Department: _____

By signing below, I hereby acknowledge the following information is true and correct:

1. Emergency Contact Information:
   - Name:
     _____
   - Address:
     _____
     _____
   - Contact Number:
     _____
   - Relationship:
     _____

2. Beneficiary Information:
   ***If more than one beneficiary attach additional information and specify %
   - Name:
     _____
   - Address:
     _____
     _____
   - Contact Number:
     _____
   - Relationship:
     _____
   - 100% of Benefit unless otherwise specified:
     _____

Signature: _____