

PAYROLL DEDUCTION AUTHORIZATION

ROCK ISLAND COUNTY GROUP HEALTH PLAN

All employees (excluding Temporary Employees) employed by the county to work 30 hours or more per week on a regular basis, and eligible dependents, will be eligible for coverage on an optional basis, following completion of 3 months employment. The following events are considered "Life Events" which allows an employee to enroll and/or make changes in dependent coverage: (1) Birth of dependent (2) Death of employee or dependent (3) Marriage (4) Divorce (5) Legal Separation (if employee chooses to terminate his/her spouse and/or dependents during a legal separation and the couple reconciles and doesn't go through with a divorce, the spouse and/or dependents are not allowed to be reinstated until the next January 1) (6) Legal Adoption (7) Change in Dependent status (8) Loss of other insurance coverage.

"Life Events" must be reported to the Human Resources Dept. within 31 days of the change and will become effective on the date of the "Life Event". Proof of life event is required i.e. marriage certificate, divorce certificate, birth certificate, etc. All other enrollment/changes must be deferred until the next January 1.

I DO NOT elect to participate in the Rock Island County Employees Health Insurance Plan. I understand that I may enroll at a later date based on "Life Events" as described above or on the next January 1.

I DO elect to participate in the Rock Island County Employees Health Insurance Plan. I hereby authorize the County of Rock Island to make payroll deductions for my share of the premium.

____ Single ____ Single+1 ____ Single+2 ____ Family

Date Signature Dept.

Date Signature Dept.

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BENEFICIARY DESIGNATION

A DEATH BENEFIT is provided for employees in the group health plan. All actively working enrollees up to age 65 will receive \$10,000.00. Those actively working employees age 65 and over and all retired enrollees will receive \$1,000.00. It will be paid to the beneficiary listed. The Human Resources Dept. will be the issuing entity. A death certificate must be provided.

I hereby make the following beneficiary/s designation:

Primary Beneficiary name Relationship Address Phone

Secondary beneficiary name (if Primary is deceased) Relationship Address Phone

Date:_____

X _____
Employee's Signature

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PERSON TO NOTIFY IN AN EMERGENCY:

NAME:_____ RELATIONSHIP_____

Home Phone_____ Employee Signature X_____