# Boone County Employees
# 2024 Insurance Plan Election Form

All benefited employees must complete and submit this form to Boone County Human Resources by **Friday, November 10, 2023.**

Name_____ Department _____

_____ I do not wish to make any changes to my health, dental, vision, or life insurance benefits for the 2024 plan year. **(Skip to #7)**
Initial Here

_____ I wish to elect the benefits outlined below for the 2024 plan year. **(Continue to #1)**
Initial Here

1. **Select Medical Plan** (For more information about both plans, please see the plan summaries handouts or view them online at www.showmeboone.com/hr/openenrollment.asp)

   _____ PPO Plan

   _____ High Deductible Health Plan *Note: To receive the employer HSA contributions, employees must enroll in a health savings account with Central Bank of Boone County. Please see the HSA eligibility checklist to see if you are eligible to open a health savings account.*

   _____ I am declining coverage under the Boone County Health Plan. **Reason:**_____

   _____

2. **Medical Coverage**

   _____I do not wish to make any changes to who is covered under my medical plan for 2024.

   ***To change who is covered under your plan, check the appropriate box below.***
   ***To remove coverage entirely, write REMOVE COVERAGE in the large space below.***

   _____ Employee Only _____ Employee and Spouse
   _____ Employee and Child(ren) _____ Employee and Family

   ***Note: You will need to submit an Anthem enrollment form to add dependents.***

   *List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2024:* _____

   _____

3. Do you or your covered dependents have any other health insurance coverage in addition to coverage with Boone County (including Medicare, Medicaid, TRICARE, or coverage under a spouse's plan)?

   _____ Yes _____ No

4. **Dental Coverage**

   _____I do not wish to make any changes to my coverage level for 2024.

   ***To change who is covered under your plan, check the appropriate box below.***
   ***To remove coverage entirely, write REMOVE COVERAGE in the large space below.***

   _____ Employee Only _____ Employee and Spouse
   _____ Employee and Child(ren) _____ Employee and Family

   ***Note: You will need to submit a Guardian enrollment form to add dependents.***

   *List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2024:* _____

   _____

***(Continued on next page)***

**5. Vision Coverage**

_____I do not wish to make any changes to my coverage level for 2024.

***To change to a different coverage level because you would like to add or remove someone, check the appropriate box below. To remove coverage entirely, write REMOVE COVERAGE below.***

_____ Employee Only _____ Employee and Spouse

_____ Employee and Child(ren) _____ Employee and Family

***Note: You will need to submit a Guardian enrollment form to add dependents.***

*List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2023:*

_____

_____

**6. Supplemental Life Insurance Coverage (additional coverage employees pay for)**

_____I do not wish to make any changes to my supplemental life insurance coverage for 2024.

***To change who is covered under your plan, check the appropriate box below.***

***To remove coverage entirely, write REMOVE COVERAGE in the large space below.***

| | | | **Yes** | **No** |
|---|---|---|---|---|
| _____ Employee | Amount of Coverage (in dollars) _____ | Add AD&D Coverage? | _____ | _____ |
| _____ Spouse | Amount of Coverage (in dollars) _____ | Add AD&D Coverage? | _____ | _____ |
| _____ Children | Amount of Coverage (in dollars) _____ | Add AD&D Coverage? | _____ | _____ |

***Note: You will need to submit a Guardian enrollment form to add dependents or change coverage amounts.***

*List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2024:*

_____

_____

**7. IMPORTANT NOTICES:**

- Your plan year and deductible run from January 1, 2024 through December 31, 2024.
- All Open Enrollment changes will take effect on January 1, 2024.
- Please notify Human Resources **within 31 days** of any life changes (birth, death, marriage, divorce, job loss, etc.), so they may assist you with adding or removing dependents.
- If you're adding or changing dependent coverage for the 2023 plan year, you must complete and submit the appropriate Anthem or Guardian forms. You can find the forms online at www.showmeboone.com/hr/openenrollment.asp or by contacting Human Resources at senyard@boonecountymo.org or 573-886-4128.
- Dependent children can be covered under the Boone County health, dental, vision, and life insurance plans until the end of the month in which they turn 26.

**8. I affirm the elections selected above for 2024 and also agree that I have received, know where to find, and understand the benefits materials and compliance documents listed below.**

- Summary of Benefits and Coverage PPO & HDHP
- Notice of Enrollment Periods
- CHIP Notice
- Health Insurance Marketplace Notice
- Enrollment Periods, Life Insurance Portability & Conversion Rights
- COBRA Notice
- Prescription Drug and Medicare Notice
- Notice of Privacy Practices
- Information Regarding your Sponsored Health Benefits
- Women's Health and Cancer Rights Act, Newborn Act

_____ _____

Employee Signature Date

***Please complete and return this form to Human Resources by November 10, 2023.***