Boone County Employees
2025 Insurance Plan Election Form

All benefited employees must complete and submit this form
to Boone County Human Resources by **Friday, Nov. 8, 2024.**

Name_____ Department _____

_____ I do not wish to make any changes to my health, dental, vision, or life insurance benefits for
Initial Here the 2025 plan year. **(Skip to #7)**

_____ I wish to elect the benefits outlined below for the 2025 plan year. **(Continue to #1)** ***Please note that all***
Initial Here ***health plan changes, including plan or dependent coverage changes, require an Anthem change form.***

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 2025. ***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 change form to change plan type or add or remove dependents.
   List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2025:

   _____

   _____

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 2025.
   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 Dental change form to add or remove dependents.
   List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2025:

   _____

   _____

(Continued on next page)

5. Vision Coverage

_____I do not wish to make any changes to my coverage level for 2025.

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 Vision change form to add or remove coverage or dependents.

List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2025:

_____

_____

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 2025.

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 Amount of Coverage (in dollars) _____ Add AD&D Coverage Yes ____ No ____

_____ Employee Amount of Coverage (in dollars) _____ Add AD&D Coverage Yes ____ No ____

_____ Employee Amount of Coverage (in dollars) _____ Add AD&D Coverage Yes ____ No ____

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

List the name and relationship (spouse, son, daughter) of any person you wish to remove from coverage in 2025:

_____

_____

7. IMPORTANT NOTICES:

- Your plan year and deductible run from January 1, 2025, through December 31, 2025.
- All Open Enrollment changes will take effect on January 1, 2025.
- Please notify Human Resources **within 30 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 2025 plan year, you must complete and submit the appropriate Anthem or Guardian forms. You can find the forms on-line 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 2025 and also agree that I have received, know where to find, and understand the benefits materials and compliance documents listed below.

- **Summary of Benefits**
- **Notice of Enrollment**
- **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 8, 2024.