

CLACKAMAS COUNTY

FLEXIBLE BENEFITS NON-REPRESENTED JOB SHARE SELECTION FORM

JOB SHARE TIME EMPLOYEES (20+ HOURS PER WEEK)

PLAN YEAR: JANUARY 1, 2011 - DECEMBER 31, 2011

<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> FAMILY STATUS CHANGE	<input type="checkbox"/> OPEN ENROLLMENT	EFFECTIVE DATE / /2011
EMPLOYEE NAME (Last, First, MI)			EMPLOYEE ID#
DEPARTMENT/DIVISION			SOCIAL SECURITY #
STATUS Check all that apply:	<input type="checkbox"/> Single <input type="checkbox"/> Single w/child(ren) <input type="checkbox"/> Married <input type="checkbox"/> Family <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Domestic Partner w/ child(ren)		BIRTHDATE
<input type="checkbox"/> PLEASE CHECK THIS BOX IF YOUR SPOUSE OR DOMESTIC PARTNER WORKS FOR CLACKAMAS COUNTY <input type="checkbox"/> PLEASE CHECK THIS BOX IF YOU ARE ADDING OR DROPPING ANY FAMILY MEMBERS			

JOB SHARE ALLOWANCE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE/DP	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
	\$339.00	\$648.00	\$571.00	\$934.00
MEDICAL				
Providence – Open Option (100112-A010)	Monthly Cost: <input type="checkbox"/> \$509.96	<input type="checkbox"/> \$1019.99	<input type="checkbox"/> \$917.93	<input type="checkbox"/> \$1,529.89
Providence – Personal Option (100112-A009)	Monthly Cost: <input type="checkbox"/> \$499.45	<input type="checkbox"/> \$998.97	<input type="checkbox"/> \$899.00	<input type="checkbox"/> \$1,498.36
Kaiser (1183-031-AB)	Monthly Cost: <input type="checkbox"/> \$543.69	<input type="checkbox"/> \$1087.38	<input type="checkbox"/> \$978.65	<input type="checkbox"/> \$1,631.08

MEDICAL OPT OUT PROVISION	
Insurance Company:	Group Name:
Primary Insured:	Group #:

DENTAL	EMPLOYEE ONLY	EMPLOYEE & SPOUSE/DP	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Kaiser (1183-050-AB)	Monthly Cost: <input type="checkbox"/> \$ 74.92	<input type="checkbox"/> \$ 148.34	<input type="checkbox"/> \$103.39	<input type="checkbox"/> \$ 177.56
ODS Incentive (10000174-0001-0008)	Monthly Cost: <input type="checkbox"/> \$ 69.00	<input type="checkbox"/> \$ 140.00	<input type="checkbox"/> \$ 98.00	<input type="checkbox"/> \$ 168.00
ODS Preventive (10000174-0001-0008)	Monthly Cost: <input type="checkbox"/> \$ 66.00	<input type="checkbox"/> \$ 132.00	<input type="checkbox"/> \$ 94.00	<input type="checkbox"/> \$ 160.00
ODS 50% (10000174-0001-0008)	Monthly Cost: <input type="checkbox"/> \$ 32.00	<input type="checkbox"/> \$ 65.00	<input type="checkbox"/> \$ 45.00	<input type="checkbox"/> \$ 77.00

FLEXIBLE SPENDING ACCOUNTS. (OPTIONAL) You <i>must</i> complete a separate enrollment form for each plan year.	
<input type="checkbox"/> Health Care \$ _____ per calendar year	<input type="checkbox"/> Dependent Care \$ _____ per calendar year

AUTHORIZATION
I authorize Clackamas County to deduct from my paycheck the amounts necessary each month for the plan choices I have selected. I understand that these premium rates may increase or decrease in future plan years and that the County will notify me of any premium changes prior to the annual open enrollment period. I also understand that my selections can be changed during a plan year only in the event of a qualifying family status change or during the open enrollment period.
Signature _____ Date _____

BENEFITS USE ONLY:

LTD	STD	EAP	ADMIN				
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