

Green County 2021 Insurance Open Enrollment

ACKNOWLEDGEMENT FORM

September 28 – October 23, 2020



_____ *I AM NOT MAKING ANY CHANGES AT THIS TIME! Nothing more Needed!

_____ *I am making changes to My Health Insurance- **Circle Changes and Complete ET-2301**

- I am changing my Health Insurance Carrier
- I would like to **ADD/REMOVE DEPENDENTS** from my current Health plan
- Changing from Single to Family Plan/Family Plan to Single Plan
- I would like to **TERMINATE MY** Health coverage **effective December 31, 2020**
- I am enrolling for Health Insurance



_____ *I am **CURRENTLY** on the Dental plan and would like to **ENROLL in 1 of the new plans being offered. All employees must enroll in a new plan (MetLife) to have coverage for 2021. Complete Application.**

_____ *I am **NOT** currently on the Dental plan but would like to **ENROLL in 1 of the new plans being offered. Complete Application**

_____ *I would like to **TERMINATE** Dental coverage **effective December 31, 2020**

_____ I am **NOT** currently on the Dental plan and I would like to **DECLINE** coverage at this time



_____ *I am **CURRENTLY** on the Vision plan and would like to **ENROLL in the new plan.**

All employees must enroll in the new plan (MetLife) to have coverage for 2021. Complete Application

_____ *I am **NOT** currently on the Vision plan but would like to **ENROLL in the new plan. Complete Application.**

_____ *I would like to **TERMINATE** Vision coverage **effective December 31, 2020**

_____ *I am **NOT** currently on the Vision plan and I would like to **DECLINE** coverage at this time



*** SHORT TERM DISABILITY:**

_____ *I AM NOT MAKING ANY CHANGES AT THIS TIME!

_____ *I am **NOT** currently enrolled in Short Term Disability but would like to **ENROLL**.

Complete Application.

_____ *I would like to **TERMINATE MY** Short Term Disability coverage **effective December 31,**



LONG TERM DISABILITY:

_____ *I am not making any changes at this time.

_____ *I am **NOT** currently enrolled in Long Term Disability but would like to **ENROLL**

Complete Application and Medical History Statement Form

_____ *I would like to **TERMINATE MY** Long Term Disability coverage **effective December 31,**



LIFE:

_____ *I would like to **CONTINUE** my Life Insurance coverages with **NO CHANGES**

_____ *I am **NOT** currently enrolled in Life Insurance but would like to **enroll: Myself, Spouse, or Child. Complete Application**

Medical Form- need for amounts more than \$20,000 on self, first time enrolling Spouse or Children and if going over guarantee amounts for them.

_____ *I would like to **TERMINATE MY** Life Insurance coverage **effective December 31, 2020**

_____ I am **NOT** currently enrolled in Life Insurance and I would like to **DECLINE** coverage at this time

Employee Name: _____ Date: _____