140 Harris Hart Road NE
Floyd, VA 24091
Telephone: (540) 745-9400 FAX: (540) 745-9496

MEMO TO: Employee Requesting Leave for Birth or Adoption of a Child

FROM: **Payroll/Benefits Office**

SUBJECT: Group Healthcare Insurance

If you are currently participating in the Floyd County Public School Division's group healthcare program, you are eligible to enroll a newborn or adopted child to your healthcare insurance policies. The birth or adoption of a child creates a qualifying event to enroll a dependent outside of open enrollment provided the enrollment application is received within 31 days of the event (birth of a child or official adoption date of a child).

To enroll/add your newborn or adopted child to your current health insurance, please complete the attached application form and submit to the Payroll/Benefits office within the required timeline noted above.

For your convenience, you may submit the attached application prior to the birth/adoption, leaving the new child's information blank, but completing all other information including your signature. Your enrollment form will be held until your child's information is provided to our office by you. Please remember to call or email our office immediately after the birth/adoption of the child so that the application to can be submitted in a timely manner. Again, your child must be enrolled within 31 days of the date of birth or adoption. If you miss the 31-day window of eligibility, you will not be able to enroll your child until the next open enrollment.

If you are currently enrolled in dental and/or vision insurance, and wish to add your new child to one or both of these benefits, please contact our office to request the additional application forms required to enroll your dependent into those plans.

If you have questions or concerns, please feel free to contact our office via email at hartmans@floyd.k12.va.us or bulsont@floyd.k12.va.us or at (540) 745-9400.

EMPLOYEE NAME: _____

EXPECTED DUE DATE: _____

☐ **I intend to enroll my child in healthcare benefits**.

☐ **I do <u>not</u> intend to enroll my child in healthcare benefits.**

Office Use Only	
Effective	Submitted

MEDICAL ENROLLMENT FORM

EMPLOYEE INFORMATION

Hire Date	Effective Date	Occupation / Location

Last Name	First Name	MI	Social Security #

Street Address	City	State	Zip	Telephone # ( )

Date of Birth	Gender	Email address:

MEDICAL PLAN ELECTION

PLEASE indicate below choice of **BENEFIT PLAN** and **WHO WILL BE COVERED** **(Check/Elect ONLY ONE):**

ELITE PPO	☐ Emp. Only	☐ Emp.+ Child	☐ Emp.+ Spouse	☐ Emp.+ Family
TREND PPO	☐ Emp. Only	☐ Emp.+ Child	☐ Emp.+ Spouse	☐ Emp.+ Family
CHOICE PPO	☐ Emp. Only	☐ Emp.+ Child	☐ Emp.+ Spouse	☐ Emp.+ Family

List all Dependents to be covered

	Last Name	First Name	MI	Gender	Date of Birth	Relationship	SS # (required)
1							
2							
3							
4							
5							
6							

Employee Signature _____ Date _____