**HEALTH BENEFITS ELECTION FORM**

***Please Print Clearly:***

**DATE:**

**EMPLOYEE’S NAME:**

**SOCIAL SECURITY NUMBER:**

**PROGRAM/ADMINISTRATION:**

I understand that I, being employed by a state agency as a Special Payments Payroll employee, am entitled to health benefits as long as I work at least 30 hours per week, or an average of 130 hours month, for a period greater than 90 consecutive days, I am eligible to enroll in all benefits offered under the State and Employee and Retiree Health and Welfare Benefits Program with the exception of flexible spending accounts. Medical and prescription drug coverage elected for myself and any eligible dependents will be subsidized at 75%. I will entirely pay for dental, term life, spouse life, child life, and/or accidental death and dismemberment coverage if I elect any of these coverages.

 I wish to enroll in the state health benefits plan(s) and have or will submit an enrollment form to my HR Office. I further understand that I am required to do so within 60 days of my **first** contract begin date.

 I do **NOT** wish to enroll in the state health benefits plan(s) and understand that this election is irrevocable after 60 days of the **first** contract begin date. I also understand that I will not be able to enroll in any of the plans until the next Open Enrollment.

**Employee Signature Hiring Manager Signature**

**Date Date**

C: Office Personnel File

**Revised 2/2018**