ALL BENEFIT ELIGIBLE EMPLOYEES: ***MUST COMPLETE THIS FORM*** *and RETURN with copy of BENEFITS CONFIRMATION(s). If you DO NOT HAVE* ***and*** *DO NOT WANT to add BENEFITS, merely check corresponding statements, sign & date and return this form. This excludes flexible spending enrollment.*

Douglas County School System

P.O. Box 1077 ~ Douglasville, GA 30133 ~ 770-651-2000 ~ www.dcssga.org
Mr. Trent North, Superintendent

Open Enrollment for 2024 Coverage, Employee Benefits Agreement Statement

I _____, do agree that I have read and understand the
(Print Name)
2024 Open Enrollment guidelines and instructions for both State Health Benefit Plan and all optional voluntary benefits offered through Douglas County School System and administered by our Agent of Record, NFP. I verify that I have followed all instructions as stated below. I fully understand that **if I do not follow online instructions, my current health insurance will default to my current Plan Option under State Health Benefit Plan beginning January 01, 2024.** I also understand that if I do not go online for Optional Insurance Benefits to make any changes, the coverage that I had from January 1, 2023 to December 31, 2023 will roll over to the 2024 plan year. I further understand that if I wish to enroll with either the **Flexible Spending Health Care or Dependent Care Flexible Spending Account, I must go online with NFP and enroll for that coverage option for 2024. Current Flexible Spending enrollment will not rollover. I further understand that I have been offered a health insurance plan that meets the minimum Affordability Care Act requirements under State Health Benefit Plan of Georgia.**

Please check the options that pertain to you:

STATE HEALTH BENEFIT PLAN (SHBP)

_____ **I am/am not currently enrolled** with State Health Benefit Plan Health insurance. As such, **I have gone online and made a new selection of health coverage**. Otherwise, I will default to my current Plan. I have attached a copy of my State Health Benefit Plan Confirmation page # **_____.**

_____ **I am currently enrolled** with State Health Benefit Plan Health Insurance. **I have gone on line and elected to discontinue my health insurance coverage beginning January 01, 2024**. I understand that I will not be allowed to enroll for health insurance again until Open Enrollment for 2025 unless I experience a qualifying event prior to the next Open Enrollment period. I have attached a copy of my State Health Benefit Plan Confirmation Page # _____.

_____ **I am not currently enrolled** with State Health Benefit Plan Health insurance, **nor do I wish to become enrolled.** As such, I am not required to go online with State Health Benefit Plan.

VOLUNTARY OPTIONAL BENEFITS (NFP)

_____ **I am currently enrolled** with optional insurance benefits such as dental, vision, disability, life insurance, and critical illness insurance. **I will keep the same coverage for 2024** as carried in 2023 and therefore, I am not required to go online and obtain a Confirmation Page for 2024 coverage unless I wish to re-enroll for my flexible spending account option for 2024. **(See last option below).**

_____ **I made changes to my voluntary coverage's** by enrolling online at www.douglascounty.bswift.com through NFP. I have attached a copy of my online confirmation form from bswift (NFP). I understand that this coverage will begin on January 01, 2024.

_____ I understand that if I wish to continue with either the **Flexible Spending Health Care or Dependent Care Flexible Spending Account**, I must go online with NFP and enroll for that coverage option for 2024. All current flexible spending benefits will end on December 31, 2023.

Employee Signature _____ Date _____

The Standard of Excellence