



THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
BENEFITS DEPARTMENT

DELETION FORM

EMPLOYEE INFORMATION

Name: _____ Personnel No.: _____ SSN: _____

Daytime Telephone No.: _____

CHECK PLAN(S) FROM WHICH YOU WISH TO DELETE DEPENDENTS

HEALTH:

AETNA

- ☐ Premier Plan HMO
☐ Premier Plus Plan HMO
☐ Premier Choice HSA

AETNA KIDS PLANS

BASIC

☐ 5 - 26

ENHANCED

☐ 5 -26

Name (Last, First)	Social Security Number	Date of Birth

DENTAL:

AETNA

DHMO

☐ Basic ☐ Enhanced

PPO

☐ Basic ☐ Enhanced

COMPBENEFITS/HUMANA

DHMO

☐ Basic ☐ Enhanced

PPO

☐ Basic ☐ Enhanced

Name (Last, First)	Social Security Number	Date of Birth

VISION:

AETNA

☐ Basic ☐ Enhanced

COMPBENEFITS/HUMANA

☐ Basic ☐ Enhanced

Name (Last, First)	Social Security Number	Date of Birth

Stop participation in the following plan(s). **Please check (✓) the applicable plan(s):**

- ☐ Enhanced Disability Insurance
- ☐ Enhanced Life Insurance
- ☐ Supplemental Cancer/Dreaded Disease Insurance
- ☐ Supplemental Health Options Policy (SHOP) Insurance

Stop participation in the following plan(s) **or** change participation amount:

- ☐ Medical Flexible Spending Account **OR** From: \$ _____ To: \$ _____
- ☐ Dependent Care Spending Account **OR** From: \$ _____ To: \$ _____

All changes are processed effective the first day of the month **following** receipt of the Deletion Form and supporting documentation. In order for the School Board to comply with **Internal Revenue Code Section 125** guidelines, changes to your initial elections are permitted under limited circumstances. Election changes must be **consistent** with the qualifying event and cause a change in eligibility. All requests must be received in the Benefits Department within **30 days of the coverage effective date (60 days for government health coverage which does not include Marketplace/ObamaCare coverage where the 30-day rule applies).** **Supporting documentation must be received with the Deletion Form** in order to be considered and processed. Support documentation/coverage **must** be from an employer, government-sponsored insurance or private policies through the Marketplace/Healthcare.gov/ObamaCare. Please allow two (2) paycycles after receipt of completed paperwork for your deletion to be processed.

Changes can only occur if one of the qualifying events listed below applies. **Please check (✓) the applicable event.**

- ☐ Change in child custody or dependent's eligibility (child acquires new coverage under other parent)
- ☐ Marriage or divorce
- ☐ The death of your spouse or dependent
- ☐ Commencement of employment of your spouse or dependent
- ☐ Change of status from part-time to full-time employment for you or your spouse
- ☐ A significant change in your spouse's employer-sponsored health coverage (i.e. Open Enrollment)
- ☐ Enrollment in government health coverage/60-day notification (i.e. Florida Healthy Kids, Medicare, Medicaid). This does not include Marketplace/ObamaCare Coverage where the 30-day rule applies.
- ☐ Enrollment in Marketplace/Healthcare.gov/ObamaCare Coverage (30-day rule applies).
- ☐ Change in residence which is outside of the Plan's Network.

EMPLOYEE SIGNATURE

DATE

Return completed form with supporting documentation to:

The School Board of Broward County, Florida
Benefits Department
7770 W. Oakland Park Blvd.
Sunrise, FL 33351
Phone: 754-321-3100
Fax: 754-321-3280
Email: benefits@browardschools.com

OFFICE USE ONLY

Effective Date: _____

By: _____