Plan Highlights

Voluntary Hospital Indemnity Insurance

Jefferson County Government

COVERAGE

Voluntary hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment.

ELIGIBILITY

Employees: All eligible employees

Dependents: You must be insured in order for Dependents to be covered.

Dependents are:

- the Insured's lawful spouse or domestic partner; and
- the Insured's children from birth to 26 years, including natural children, legally adopted children, children who are dependent on the eligible employee during the waiting period before adoption, stepchildren, and foster children. Foster children must be in the custody of the eligible employee to be considered a Dependent; and an eligible employee's child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on the eligible employee for support and maintenance.
- A person may not have coverage as both an Employee and Dependent.

FEATURES

- Guaranteed issue; no medical questions
- No pre-existing conditions exclusions
- Mental & Nervous and Substance Abuse treated same as any other hospital admission
- No deductibles
- Eligible for continuation of coverage
- HIPAA privacy compliant
- Overlying Major Medical Plan NOT Required*
- Coverage Offered on a Voluntary Basis

*Overlying major medical plan is required for all California residents.

CONTRIBUTION REQUIREMENTS

Coverage is 100% employee paid.

BENEFITS

Hospital Room & Board Benefits	
Room & Board Benefit per Day (180 Daily Benefits per Coverage Year)*	$100
Hospital Critical Care Unit Benefits (Paid in addition to Room & Board Benefit)	
Critical Care Unit Benefits per Day (30 Daily Benefits per Coverage Year)	$200
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$500
Non-Insurance Services	
On-Call Travel Assistance	Included

**In no event will the Daily Benefits exceed 180 daily benefits per Coverage Year.*

MONTHLY PREMIUM

Employee Only	$14.40
Employee + Spouse	$33.48
Employee + Children	$22.30
Employee + Family	$40.40

EXCLUSIONS

Benefits will not be paid for any loss caused by: suicide; war; assault/felony; dental care except hospitalizations for the care of sound, natural teeth and gums required on account of accidental injury that happens while covered, and that occur within 6 months of the accident; hospitalizations that occur while outside the United States of America; or care or treatment rendered in connection with cosmetic surgery, except hospitalizations for cosmetic surgery needed for breast reconstruction following a mastectomy or for an accident that happens while covered. The cosmetic surgery needed for an accidental injury must be performed within 90 days of the accident. For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for benefits. This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Voluntary Hospital Indemnity Plan

Employee Enrollment Form

You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.

SECTION A — INFORMATION ABOUT YOUR EMPLOYER

Employer Name: Jefferson County Government	Effective Date:
Bill Group Number:	Location/Division:

Application Type:

☐ Initial Eligibility / New Hire ☐ Other (Describe):

Nature of Change (If marriage, divorce or birth of a child, please provide documentation):

☐ Change in Status: Date of Change:

SECTION B — INFORMATION ABOUT YOU

Social Security Number:	First Name:	Middle Initial	Last Name:

Date of Birth:	Date of Hire:	Gender: ☐ Male ☐ Female

Mailing Address:	City:	State:	Zip Code:

Phone Number:	Email Address:

SECTION C — ENROLLMENT SELECTION

It is important that you follow the directions when making your election; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section D; otherwise, their enrollment may be delayed. Costs listed below are monthly amounts.

Make your selection by putting an in ☒ the box next to the selection you want. List your Dependents on the back of this form.

Voluntary Hospital Indemnity Plan	
Employee Only	☐ $14.40
Employee + Spouse	☐ $33.48
Employee + Child(ren)	☐ $22.30
Employee + Family	☐ $40.40
DECLINE COVERAGE	☐

I wish to participate in the benefit plan that I've selected above and I authorize my employer to deduct the required costs from my paycheck.

APPLIES TO CALIFORNIA RESIDENTS—I certify that I (and any dependents that I enroll) have coverage for comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan and I am eligible to enroll for this hospital confinement indemnity insurance plan.

Your Signature:	Date:

(OVER PLEASE)

SECTION D — WHICH DEPENDENTS WILL BE COVERED?

1.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
2.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
3.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
4.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
5.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
6.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.

Dependent Not Living with You:	First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:		State:	Zip Code:

If you have additional dependents or addresses for those dependents not living with you, please record all requested information on a separate sheet and attach it to this form.