Escambia County Board of County Commissioners
Benefit Election Change Form

Employee Name: _____ **Social Security #:** _____

Department/Appointing Authority: _____

Please make the following change(s) to my payroll deduction(s) to become effective on this date (mm/dd/yy): _____ **OR** ☐ **Immediately.**

	Deduction Amounts Per Pay Period			
	Increase		Decrease	
Health Savings Account (HSA)	from $ _____	to $ _____	from $ _____	to $ _____
Deferred Compensation				
Transamerica	from $ _____	to $ _____	from $ _____	to $ _____
Nationwide	from $ _____	to $ _____	from $ _____	to $ _____
ICMA	from $ _____	to $ _____	from $ _____	to $ _____
Valic	from $ _____	to $ _____	from $ _____	to $ _____

Long Term Disability ï Madison National Life

☐ Cancel premium deduction for optional coverage

NOTE: **If any of the following deductions for *Life Insurance, Vision Care or Other Insurance Companies* are currently flexed (pre-taxed), changes may only be made during open enrollment or with an eligible family status change or other life event. Please examine your most recent pay stub to determine flex deductions or contact the Office of Human Resources, Benefits Section, at 595-4767, for additional information.**

Life Insurance

Cancel	☐	Supplemental life insurance		
Decrease	☐	Life insurance amount:	from $ _____	to $ _____
Cancel	☐	Dependent life insurance (**$1.49**)		
Cancel	☐	Child life insurance		
Cancel	☐	Spouse life insurance		

Vision Care (Employee must maintain coverage for 1 year before changes can be made)

Change ☐ from: **FAMILY** to **SINGLE** @ **$ 3.51** per payday
☐ from: **SINGLE** to **FAMILY** @ **$10.05** per payday

☐ Cancel premium deduction

Other Insurance Companies (Changes other than cancellation must be made through the company representative.)

Cancel premium deduction(s) for the following:

☐ AFLAC ☐ American Heritage ☐ Colonial Life ☐ American General **Life**

_____ _____

Employee Signature Date