

**INDIAN RIVER COUNTY
HEALTH INSURANCE ELECTION**

Employee's Name: _____ Employee #: _____
~~~~~  
~

Please check the appropriate box for health insurance benefits.

- I elect single coverage only. This coverage does not include any dependent coverage.
  
- I elect dependent coverage. This coverage includes my spouse and any dependent children. By electing this coverage, I authorize the County to deduct the current amount approved by the Board of County Commissioners for such coverage, which is **\$217.50 / monthly**.
  
- I elect Life Insurance only.
  
- Delete Coverage.  
Coverage Termination date:  
Reason:

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Date of Hire: (FT) \_\_\_\_\_

Effective Date of Health Insurance: \_\_\_\_\_

**Return Forms To:**

**The Human Resources Department within 30 days of hire to ensure coverage.**