P&A GROUP
EST. 1975
Employee Benefits

RE: Orange County Sheriff's Office Retiree
OPEN ENROLLMENT 10/1/2026

Orange County Sheriff's Office Retiree is holding their Open Enrollment Period. During this time, participants, continuing coverage through the Retiree program have the right to change their group health plans and make changes to their coverage tier levels - including adding family members to the plan.

This is a passive enrollment period, so no action is required if you do not wish to make changes. Your current benefit elections will automatically carry over from the previous plan year.

Orange County Sheriff's Office is holding their Retiree Open Enrollment Period. During this time, participants continuing coverage through the Retiree program have the right to add, change or cancel their coverage - including adding family members to the plan. If you are electing to make changes, 10/01/2026 please indicate all plan types you would like effective 10/01/2026 including those you are currently enrolled in. There have been no changes to the insurance carriers. However, Medical rates have changed. Dental and Vision rates remain the same.

Again, you are not required to submit your Open Enrollment packet if you do not wish to make any changes. Summaries of Benefits and Coverage (SBCs) are available upon request. For additional information, please contact the P&A Group directly.

Complete Open Enrollment Change Form on following page
Reply no later than **8/31/2026**

Fax: 877-855-7107
Email: GIBilling@padmin.com
Mail: 6400 Main Street, Suite 210, Williamsville, NY 14221

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Orange County Sheriff's Office Retiree

10/1/2026 Open Enrollment Change Form

Name:
Address:
City, State, Zip:

Please return this form no later than 8/31/2026
Circle the TIER of the benefit you want to be enrolled in for 10/1/2026
Return to P&A Group by one of these options:

Fax: 877-855-7107

Email: COBRA@padmin.com

Mail: 6400 Main Street, Suite 210, Williamsville, NY 14221

Carrier	SINGLE	EE+SP	EE+CHILD(REN	FAMILY
Humana DHMO Plan	$14.26	$28.51	$32.07	$51.59

Carrier	SINGLE	EE+SP	EE+CHILD(REN	FAMILY
Humana Dental PPO Plan	$23.14	$44.95	$42.81	$97.56

Carrier	SINGLE	EE+SP	EE+CHILD(REN	FAMILY
Humana Dental PPO Plus Plan	$30.23	$60.59	$70.37	$100.73

Carrier	SINGLE	EE+SP	EE+CHILD(REN	FAMILY
CIGNA Choice Fund Open Access Plus HSA Gold	$1,030.00	$2,018.70	$1,653.60	$2,844.70

Carrier	SINGLE	EE+SP	EE+CHILD(REN	FAMILY
CIGNA Open Access Plus (Green Plan)	$1,005.50	$1,970.70	$1,614.40	$2,777.10

Carrier	SINGLE	FAMILY
Humana Vision Plan	$5.17	$13.43

Signature: _____ **Date:** _____

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Please provide all information for each person to be covered under the plan(s)

Name:_____

Date of Birth:_____ **SSN:**_____

Relationship:_____

Please Circle your Benefits: DENTAL HEALTH VISION

Name:_____

Date of Birth:_____ **SSN:**_____

Relationship:_____

Please Circle your Benefits: DENTAL HEALTH VISION

Name:_____

Date of Birth:_____ **SSN:**_____

Relationship:_____

Please Circle your Benefits: DENTAL HEALTH VISION

Name:_____

Date of Birth:_____ **SSN:**_____

Relationship:_____

Please Circle The Benefits: DENTAL HEALTH VISION

Rev. 3/06

INS DOC

FLORIDA RETIREMENT SYSTEM PENSION PLAN

Insurance Payroll Deduction Authorization Form

P&A GROUP

Approved Deduction Name

P&A Group

Retiree Contact Person

716-362-2611

Retiree Contact Person's Telephone No

The payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: _____ **DEDUCTION CODE : 450 (Health)**

PAYEE NAME: _____ **DEDUCTION CODE :** _____

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium changes as directed by my insurance provider. I understand that my insurance provider is responsible for notifying me of premium changes as they occur and for any refunds (if applicable). If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's Signature:

Signature required if no premium deduction (for above deduction code) from previous month's pension payment.

Address: _

Date: Telephone No:

Date of Birth: _____ Date Member Retired: _____

Insurance office use only. The Division of Retirement will not use this information.

Insurance provider staff must fax or mail a completed authorization form for all new deductions (or restarted deductions) to the Division of Retirement. MAIL: Division of Retirement, Retired Payroll Section, PO Box 9000, Tallahassee, FL 32315-9000; **FAX: 850-410-2010**

COBRA/Direct Billing Participant Use ONLY | ACH Agreement Form

P&A Group: 6400 Main Street, Suite 210 Williamsville, NY 14221 | Fax: 716-855-7107

☐ New ☐ Change to existing

Please complete this form in its entirety to authorize automatic deductions from your checking or savings account to pay for your health insurance premium(s). You will no longer receive a paper bill in the mail and the auto deductions will occur approximately the 5th of each month. A confirmation letter will be sent to you to confirm when the automatic deductions will begin

Former Employer Name: _____

Your Name: _____

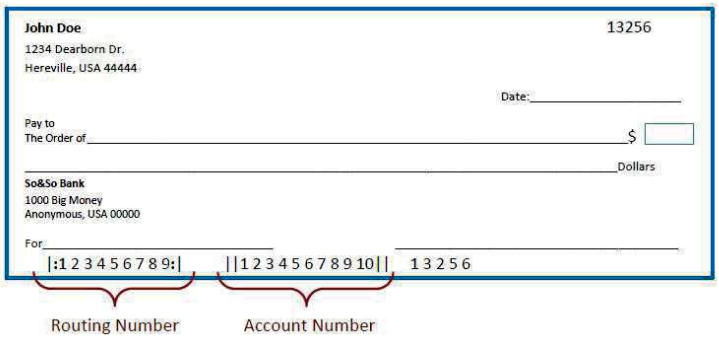
SSN: _____ Phone: _____

E-mail: _____

Banking Institution: _____

Bank Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Routing Number: ☐☐☐☐☐☐☐☐☐
*Must begin with 0, 1, 2, or 3



Please send a copy of a voided check or bank form showing the information above along with this form.

Form Submission Options

This form is also available online. To complete the online authorization form, go to www.padmin.com, login to your account and choose "Direct Deposit" from the "Quick Links" box on the left, follow the prompts on the page and submit. You can also fax or mail this form to P&A Group.
Fax: (877) 855-7107 | **Mail**: P&A Group, Group Insurance Department, 6400 Main Street, Suite 210 Williamsville, NY 14221

I hereby authorize The P&A Group to automatically withdraw funds from my checking or savings account (as indicated above) in the amount of my health insurance premium automatically. I can cancel my automatic payment anytime by submitting a request in writing to P&A Group. I consent that this arrangement will remain in effect until canceled by me or my banking institution. I understand that the change may take up to 30 days to process.

I understand that this is my responsibility to notify P&A of all future changes to my bank account number and routing number. If I fail to notify P&A of changes of this nature, I will be responsible for reimbursing P&A for all applicable bank charges.

Authorized Signature: _____ Print Name _____

Date _____

PLEASE NOTE THAT ANY ACCOUNT CHANGES MUST BE COMMUNICATED IMMEDIATELY BY USING THIS FORM TO NOTIFY P&A IN ORDER TO AVOID REJECTION FEES AND/OR PENALTIES.