ACADEMY SCHOOL DISTRICT 20
INSURANCE ENROLLMENT/CHANGE FORM

PLAN YEAR 2014-2015 (through 6/30/2015)

PART-TIME EMPLOYEES (Salaried employees working .5-.79 FTE, and classified [non-Transportation] employees working 668-1067 hours/year)

Employee's Name: (Last, First, Middle Initial)	Social Security #: - -	Date of Birth: (mm/dd/yyyy)
Employee's Address: Street	City	State / Zip Code
Employee's Home Phone #:	Employee's **Home** E-mail Address:	
□ Male □ Female	□ Single □ Married □ Separated □ Divorced □ Widowed	

□ **NEW ENROLLMENT (Check one) – Employer will complete all shaded areas.**	**Date of Event**	**Effective Date of Coverage**
□ New Hire □ Rehire		
□ Newly Eligible (Increased FTE or increased hours resulting in change from ineligible to eligible status)		

□ **CHANGE (Check all that apply) – Employer will complete all shaded areas.**	**Change Date**	**Add/Drop/Change Effective Date**
□ Name □ Address □ Phone Number		
□ Qualifying Event □ Add employee/dependent(s) to coverage **(Employee must complete Qualifying Event Form and the Enrollment/Change Form)** □ Drop employee/dependent(s) from coverage **(Employee must complete Qualifying Event Form and the Enrollment/Change Form)** □ Increased FTE or increased hours, resulting in change from part-time to full-time status		

MEDICAL INSURANCE	**Employee Only**	**Employee & Spouse**	**Employee & Children***	**Employee & Family***
Kaiser Permanente HMO	□ $292.09/month	□ $779.45/month	□ $751.86/month	□ $1235.94/month

I elect to pay my medical premium payroll deductions as: □ Before-Tax □ After-Tax

_____ I am declining medical insurance, and I elect to have my employer contribution designated as taxable cash because I have health insurance under another plan.
Proof of other coverage is required in order to be paid cafeteria dollars. (Attach completed "Benefits Waiver Form" and a copy of insurance card or other proof of current coverage.)

I currently have medical insurance coverage with: _____

DENTAL INSURANCE	**Employee Only**	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Delta PPO	□ $2.79/month	□ $38.31/month	□ $51.41/month	□ $90.17/month
Delta Buy-up (2 yr. commitment)	□ $11.06/month	□ $52.29/month	□ $71.61/month	□ $119.87/month

I elect to pay my dental premium payroll deductions as: □ Before-Tax □ After-Tax

_____ I am declining dental insurance.

VISION INSURANCE	**Employee Only**	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Vision Service Plan	□ $7.65/month	□ $12.81/month	□ $13.08/month	□ $21.09/month

I elect to pay my vision premium payroll deductions as: □ Before-Tax □ After-Tax

_____ I am declining vision insurance.

VSP

LIFE INSURANCE	**Employee Only**	**Family**
Standard Insurance	□ $0.00	□ $1.00/month

PLEASE COMPLETE BENEFICIARY AND DEPENDENT INFORMATION AND SIGN ON REVERSE SIDE →

LIFE INSURANCE BENEFICIARY DESIGNATION

I request that the beneficiary under this group certificate be as indicated below. Unless otherwise provided in this request, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the group policy. The right of the insured or owner, if other than the insured, to change the beneficiary is hereafter reserved. In the event that there are additional beneficiaries, please attach an additional page.

PRIMARY

Name / Address (if different from employee's)	Social Security #	Date of Birth (mm/dd/yyyy)	Gender	Relationship	% Designated
	- -		F M		
	- -		F M		

SECONDARY (Pays only if there are NO surviving primary beneficiaries)

Name / Address (if different from employee's)	Social Security #	Date of Birth (mm/dd/yyyy)	Gender	Relationship	% Designated
	- -		F M		
	- -		F M		

DEPENDENT INFORMATION: Check which coverage(s) you are selecting for each dependent. If you have more than seven dependent children, please attach additional page.

Name (Last, First, MI)	Social Security #	Date of Birth (mm/dd/yyyy)	Gender	Medical	Dental	Vision	Basic Life
Spouse:	- -		F M				
Dependent Child*:	- -		F M				
Dependent Child*:	- -		F M				
Dependent Child*:	- -		F M				
Dependent Child*:	- -		F M				
Dependent Child*:	- -		F M				
Dependent Child*:	- -		F M				
Dependent Child*:	- -		F M				

READ CAREFULLY AND SIGN:

To the best of my knowledge, the information I have provided is complete and true. I understand that falsification by me may allow recovery of payments, cancellation of coverage and a refusal to pay claims. I authorize, as permitted by law, any provider, insurance company, employer or healthcare organization to release any information on me or my dependents regarding medical, dental, mental, substance abuse, treatments or benefits payable, including disability or employment-related information, to the insurers I have selected for benefits coverage. The insurers also have my permission to give confidential information to any person or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, performance of the plans, assessing quality and accessibility of healthcare services or reporting to third parties involved in plan administration. As per Administrative Policy GBE, the provisions of the Health Insurance Portability and Accountability Act (HIPAA) shall govern access to, and information about, employee health records. Additionally, the District does not receive employee protected health information from its healthcare provider, except with a valid HIPAA authorization form from the individual plan member. I am making this authorization for myself and as the agent or representative of my spouse and any dependent children. I agree, for myself and my dependents, that, in the event any services provided are the primary responsibility of any other party, to fully inform the health plan or plan administrator and execute such assignments or other documents which may be necessary to enable the plans to recover the value of the services provided. I also agree that, in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by these plans, I will immediately reimburse the plans to the extent of services provided or to the limit provided by state and federal law. This includes coordination with no-fault automobile insurance as prescribed by state law and as explained in plan documents.

I understand that, unless I elect post-tax deductions, pre-tax deductions will be taken through an IRS Section 125 Plan. I also understand that the choices I have elected must remain in effect for the entire plan year except for qualified events such as marriage, divorce, birth, adoption, eligibility of a dependent child, or significant changes to my or my spouse's employment status or health plan cost or coverage. I understand that, if I decline coverage for myself or my dependents without having other coverage, my eligible dependents and I may be subject to the late entrant limitations if I elect coverage in the future. The limitations may include a delayed effective date of up to three months, or pre-existing condition limitations of up to eighteen months.

Employee Signature: _____ Date: _____