JOB TITLE:_____

Durango School District 9-R Benefit Enrollment Form

EMPLOYEE – PLEASE COMPLETE ALL UNSHADED AREAS

EMPLOYEE INFORMATION

_____ -_____ - _____ _____ M F _____ ____ / ____ / ____

Social Security # | Last Name | First Name | MI | Gender | Birth Date

_____ _____ _____ _____

Street Address | City | State | Zip | Home Phone Number | Work Phone Number

TRANSACTION INFORMATION

TYPE OF ACTION • Effective Date (/ /)

- ☐ New Hire
- ☐ Re-Hire
- ☐ Open Enrollment
- ☐ Initial Enrollment
- ☐ Waived

CHANGING INFORMATION • Date (/ /)

- ☐ Cancel Dependents
- ☐ Cancel All Coverage
- ☐ Qualifying Event: _____

*NOTE: If adding dependent(s) other than at open enrollment, requires Certificate of Creditable Coverage showing previous coverage and coverage termination dates.

COVERAGE ELECTIONS

MEDICAL COVERAGE	MEDICAL PLAN	DENTAL	VISION	LIFE / DISABILITY
Anthem BC/BS	**Anthem BC/BS**	**Delta Dental of Colorado**	**VSP**	**Anthem BC/BS**
Election ☐ Employee Only ☐ EE & Spouse ☐ EE & Child(ren) ☐ EE & Family	**Election** ☐ PPO Plan ☐ EPO Plan ☐ HSA Plan	**Election** ☐ Employee Only ☐ EE & Spouse ☐ EE & Child(ren) ☐ EE & Family	**Election** ☐ Employee Only ☐ EE & Spouse ☐ EE & Child(ren) ☐ EE & Family	**Life / AD&D Election** ☐ Employee Only **LTD Election** ☐ Employee Only

PARTICIPANT INFORMATION

Relationship	Last Name First Name MI	Social Security #	Gender (M/F)	Date of Birth (MM / DD / YYYY)
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

PRIOR MEDICAL COVERAGE: Did you and your dependent(s) have medical coverage prior to enrolling with Durango School District 9-R?

☐ Yes ☐ No Begin Date:_____ End Date:_____ Carrier_____

According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage (Certificate of Creditable Coverage). We reserve the right to request a copy of this certification prior to your enrollment in the Durango School District 9-R sponsored plan.

OTHER COVERAGE: Will you or any of your dependent(s) also have coverage on another health plan? ☐Yes ☐No Carrier:_____

CERTIFICATION

I declare that I have read the information on both sides of this form including the Authorizations and Arbitration Agreement Provisions section prior to completion. I also declare that the information above is true and that I am on payroll as an active employee on the date of enrollment. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I am entitled to a copy of this signed authorization for my files. I will verify my pay stub to assure accuracy of any salary deductions I have elected.

EMPLOYEE SIGNATURE _____ DATE:_____

	Health	Dental	Vision	Life / LTD	COBRA	ACA
IVEE						
ONLINE						

Section 125 Salary Reduction Agreement – This section must be filled out in order for premiums to be deducted from your pay and benefits to begin. **If this section is not completed, premiums will default to the after tax deduction.**

☐ Section 125 Pre-Tax Payroll Deduction ☐ After-Tax Payroll Deduction

I hereby authorize the *above* payroll reductions as my contribution to my employer's Section 125 Cafeteria Plan.

I understand that:

1) Changes in the Cafeteria Plan elections can only be made at the end of the plan year unless due to and consistent with a valid status change and such other *events* as would permit a revocation or change of election under IRS 125 regulations. Participation in this plan will automatically cease upon termination of employment. For special rules affecting your plan, please contact the benefits office. PERA CONTRIBUTIONS ARE REDUCED BY ANY SECTION 125 AMOUNTS.

2) Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage. Premiums charged for insurance coverage may be adjusted by the insurance carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.

Basic Life / AD&D Insurance – Eligible employees automatically receive a benefit of $20,000 of coverage provided through Anthem Blue Cross Blue Shield. This amount could be recued based on age.

Primary Beneficiary(ies) _____%

Last Name First Name MI Relationship Phone Number

Address Date of Birth

Secondary Beneficiary(ies) _____%

Last Name First Name MI Relationship Phone Number

Address Date of Birth

☐ Check here if your beneficiary is a not-for-profit organization

When you enroll, you must name a beneficiary. You may name a beneficiary or change your choice of beneficiary at any time by written request. Changes in beneficiary designation will be effective on the date you sign the form. You may name more than one person. If you name more than one person, you should specify the percentage you wish paid to those persons (equaling 100%). Otherwise, the beneficiaries will share the benefit equally. If a trustee is named beneficiary, show the name and address of the trustee and the date of the agreement. You should appoint a legal guardian if your beneficiary(ies) are minors. If no beneficiary is named, or your beneficiary dies before you, the benefits would be paid as described in the benefit booklets and the insurance policy.

AUTHORIZATIONS, ARBITRATION AGREEMENT PROVISIONS

Anthem Blue Cross / Blue Shield:

Non-Participating Provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
Effective Date: The effective date of coverage is subject to Anthem BC/BS approval.

AUTHORIZATION

I certify that all information supplied on this form is true to the best of my knowledge. I understand that all benefits for me and my eligible dependents will be provided in accordance with the plan contract. I agree to abide by the terms and conditions governing membership and receipt of health services *covered* by the plan in which I have enrolled, and agree to the following provisions:

a. I understand that I am responsible for reporting to my employer promptly any changes in my marital status, the number of my eligible dependents, or any change in my residence.
b. I agree that any hospital benefits payable on my account under my employer's Group Medical Benefits Plan may be paid directly to the provider of care.
c. I understand and agree that no benefits shall take effect until this enrollment form is approved by the carrier. Upon such acceptance, the selected carriers shall as soon as possible issue an identification card(s) to the member to evidence *coverage* hereunder.
d. I understand that I must be actively at work on my effective date of *coverage,* if not, my effective date of *coverage* is the date I return to active work and am otherwise eligible for *coverage.*
e. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
f. I agree that in the event any health services provided to me or my family member(s) by the plan(s) in which I have enrolled are the primary responsibility of Medicare or the state industrial insurance system or any third party on account of any injury or damage, I will fully inform the plan(s) and will execute such assignments, liens or other documents which may be necessary to enable the plan(s) to *recover* the value of services provided. I further agree that in the event I or any of my family members collect benefits or damages from Medicare or the state industrial insurance system or reimbursement from a third party, I will immediately reimburse the plan(s) to the extent of services provided.

I authorize my employer to deduct from my pay check the required premiums on a pre-tax basis (if selected *above).* I understand that these elections are irrevocable and cannot be changed during this Plan Year, unless I have a qualified family status change and complete a Change of Election form within 30 days of the change. I have been advised that my PERA benefits may be reduced by these elections. I agree that my employer may reduce or cancel these elections if necessary to comply with Internal Revenue Code.

I agree for myself and my dependents to be bound by the terms of the plan documents under which coverage is provided. Further, I acknowledge that if I am declining enrollment for my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll my dependents in this plan, provided that I request enrollment within 30 days after other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 30 days following that event.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

EMPLOYEE SIGNATURE _____ DATE:_____