## ACSHIC Enrollment Form - Frazier School District

**Effective Date:** _____

| LAST NAME | FIRST NAME | MI |
|---|---|---|
| | | |

| SOCIAL SECURITY NO. | DATE OF BIRTH | GENDER | MARITAL STATUS |
|---|---|---|---|
| | | ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| Coverage Type | Election | Coverage Level |
|---|---|---|
| Medical/RX | ☐ **EPO** ☐ **PPO** | ☐ Individual ☐ Parent/Child ☐ Parent/Children ☐ Employee/Spouse ☐ Family |

**Dependent Election**

| | NAME | SSN | D.O.B. | GENDER | RELATIONSHIP |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |

***Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. For information on changes outside of open enrollment please see the HIPAA Notice of Special Enrollment Rights.***

**Waiving Coverage (continued on reverse, completion required to waive)**

☐ I **decline** to enroll in medical coverage for myself and any/all dependents. By checking this box, I understand that I/we will not be enrolled in any of the above coverages. I understand that this waiver of coverage may affect my ability and that of any/all dependents to obtain coverage at a later date, specifically, except during applicable "Special Enrollment Periods". As a benefits-eligible employee waiving medical coverage through Frazier School District, completion of the reverse side of this form (and providing the necessary documentation) indicates my election of the applicable medical allowance in lieu of medical enrollment.

**Enrollment Attestation**

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled. By signing below, I also acknowledge contents of the HIPAA Notice of Special Enrollment Rights.

**Employee Signature (Acceptance and Waiver)** _____ **Date** _____ **Authorized Employer Signature** _____ **Date** _____

**Waiving Coverage (continued from front)**

The parties hereto agree that if the Frazier employee entitled to the health insurance benefits set forth on the reverse side of this form is insured by the same or a similar plan elsewhere, that employee shall so notify the District of that fact and make an election as to the insurance plan with which he/she will choose to be insured.

Employees covered by a spouse's insurance or other similar insurance coverage may choose not to be in the insurance program offered by the District. Employees making such a choice shall receive five hundred dollars ($500) per month through payroll in lieu of the District plan enrollment-- unless specified elsewhere-- by providing the following.

If enrolled in spouse's coverage, please complete the following and provide documentation from the plan coordinator/employer verifying enrollment for yourself and any/all dependents. If enrolled in other similar coverage, complete the name of plan, account number of plan, and provide documentation.

| | | | |
|---|---|---|---|
| Name of Employee | _____ | Name of Plan | _____ |
| Name of Employer | _____ | Account Number of Plan | _____ |
| Address of Employer | _____ | | |
| | _____ | | |
| | _____ | | |
| Employer Telephone Number | _____ | | |

I hereby verify the statements set forth in this form are true and correct to the best of my knowledge, information and belief.

_____ _____

**Employee Signature (Waiving Coverage)** **Date**

# Enrollment/Change Form

United Concordia Dental / Davis Vision

School District _____

## SECTION I - TO BE COMPLETED BY EMPLOYEE/RETIREE

Use this form to select/change a medical, dental and/or vision plan and coverage level. **Return this completed form within 31 days of your full-time date of hire or qualifying event, along with any required documentation i.e. marriage certificate, birth certificate, etc.**

Reason For Completing this Form: ☐ New Hire ☐ Current Employee Enrolling ☐ Change ☐ Termination

Type of change: ☐ Address ☐ Name ☐ Add or Remove Spouse/Dependent ☐ Waive Coverage

Hire Date: | Benefit Type (check all that apply): ☐ Dental ☐ Vision

| Name | Social Security Number | Date of Birth | Male/Female | Add or Remove |
|---|---|---|---|---|
| Employee/Retiree | | | ☐ M ☐ F | |
| Spouse | | | ☐ M ☐ F | |
| Dep | | | ☐ M ☐ F | |
| Dep | | | ☐ M ☐ F | |
| Dep | | | ☐ M ☐ F | |
| Street Address | | | | |
| City | State | | Zip Code | |

**Required Documentation** Provide the required document along with this form. Refer to the Instructions for Benefit Elections/Changes to determine what documents you need to provide. Your benefits will not be updated until all documentation is received.

*I certify that the above information is true and correct. For New Hire: By not enrolling in certain benefits at this time (within 31 days of full-time date of hire or within 31 days of a qualifying change in family status), I understand that I will be unable to enroll or make changes again until the next annual Open Enrollment period.*

Signature of Employee/Retiree: Date:

## SECTION II - TO BE COMPLETED BY SCHOOL DISTRICT

District: | Representative:

Effective Date of Change: | Date Section I Received:

| Group #(s) | Current (if applicable) | New | Coverage Level/Tier |
|---|---|---|---|
| Dental | | | ☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM |
| Vision | | | ☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM |
| | | | |

**Type of Activity (check all that apply):**

☐ New Hire
☐ Current Employee Enrolling
☐ Termination
☐ Add Spouse/Dependent
☐ Remove Spouse/Dependent
☐ Change of Address
☐ Name Change
☐ Act 110 / Act 43 Eligible
☐ Waive Coverage
☐ COBRA (check all that apply and indicate Qualifying Event below)
Dental Vision Other

**Qualifying Event or Change of Family Status:**

☐ Newborn
☐ Adoption
☐ Retirement
☐ Marriage
☐ Divorce
☐ Death
☐ Voluntary Resignation
☐ Involuntary Resignation
☐ Legal Guardianship
☐ Court Ordered
☐ Over Age Dependent
☐ Medicare Entitlement
☐ Other _____

**Required documentation must be collected, reviewed and approved by district prior to enrollment. DO NOT send documentation to ReSo; keep at district for auditing purposes.**

Signature of District Rep: Date:

-required for processing -

# Notice of Special Enrollment Rights

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), group health plans such as ACSHIC are required to provide active employees, their dependents and COBRA qualified beneficiaries with special enrollment opportunities for certain situations.

You may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for coverage under another plan, such as a spouse's plan. The following are some events that may trigger a Special Enrollment Event:

Loss of eligibility for other coverage

- Due to divorce or legal separation;
- Dependent loss of eligibility due to age under a parent's plan;
- Death of an employee's spouse which leaves the spouse with no coverage;
- Spouse's loss of employment that terminates insurance coverage; and
- Spouse no longer eligible for insurance coverage for other reasons.

**You must request enrollment within 30 days after your or your dependents' other coverage ends.**

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. **However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.**

If you or a dependent have exhausted entitlement to benefits under COBRA under a different group health plan (usually after 18 or 36 months) you may be able to enroll yourself and/or your dependents under the ACSHIC Plan. **However, you must request enrollment within 30 days after the COBRA coverage ends.**

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

You must notify ***YOUR HR DEPARTMENT*** within the required period after a Special Enrollment Event takes place. Coverage will not be provided if the request is not made in a timely manner.

If you are enrolling in the Plan for the first time, you must complete an enrollment form and provide the supporting documentation for your Special Enrollment Event. If you are currently enrolled and adding a dependent, then a written request is required along with the supporting documentation.

Please contact ***YOUR HR DEPARTMENT*** if you have any questions regarding the submittal of a Special Enrollment Request.