Employee Enrollment Form for Clarkston School District

Dental and Vision - are Underwritten by Regence BlueShield of Idaho

Check one: ☐ Open Enrollment ☐ Add Dependent(s) ☐ Delete Dependent(s) ☐ COBRA

☐ New Employee ☐ Change Name or Address ☐ *Terminate Coverage*

Effective Date: _____ **Group Number: 10000993**

Plans Available: ☐ Dental $1,000 Annual Max ☐ Dental $2,000 Annual Max ☐ Vision

To be completed by Employer: Job Title:	Date of Hire	Hours worked per week	Date of qualifying event	**Insurance Company Use Only:**

Employee Name (Last)	(First)	(MI)	Social Security Number	
Address	**City**	**State**	**Zip**	**Phone Number:**

Marital Status: ☐ Single ☐ Married ☐ Divorced Date of change:	Domestic Partner : ☐ Yes ☐ No	Sex (M/F)	Date of Birth

Are you and/or your dependents currently covered by Medicare? ☐ Yes ☐ No
If yes, please provide Medicare Number:

What type of member card would you like to receive?
☐ Family Level Card (all members listed on the same card) ☐ Member Level Card (each member on a separate card)

DEPENDENT INFORMATION: *Please list only those dependents you wish to **ADD (or DELETE)**.*

	ADD X	DEL X	Vision	Dental	Last Name	First Name	MI	Birth date M/D/Y	Gender M/F	Social Security Number	Relationship to Employee
Spouse/ Domestic Partner			☐	☐							
Child			☐	☐							
Child			☐	☐							
Child			☐	☐							
Child			☐	☐							

OTHER COVERAGE: (Coordination of Benefits)

Do you or your dependents have other **dental / vision** coverage? ☐ Yes ☐ No

If yes, Who does other dental / vision insurance cover? (check all that apply): ☐ Employee ☐ Spouse ☐ Children

Name of Insured:	Social Security Number:	Group (Policy) Number:
Name of Insured's Employer:	**Name of Insurance Carrier:**	**Date Coverage Began:**

☐ **Please check if Waiving Dental / Vision Coverage - I understand that benefits have been offered to me, and I hereby decline coverage.**

☐ **Premium Conversion Plan. I decline – please deduct contribution on an after-tax basis (see back)**

I certify that all statements on this enrollment form are true and correct to the best of my knowledge and belief. I have read, understand, and accept the terms and conditions as stated on the back of this form. I authorize my employer to make the necessary premium deductions from my paycheck.

_____ _____

Employee' Signature Date

My signature on the front of this form indicates I have read and understand this Enrollment/Change Form and the descriptive materials provided. This form is binding and cannot be revoked or modified except as described in the descriptive materials provided. Any election I make now will remain in effect during this and all subsequent plan years until I specifically revoke or change my election by completing a new Enrollment/Change form.

I also understand that my salary will be reduced by the amount required (if any) for the benefits I have elected. I understand that paying contributions with pretax dollars is intended to meet Internal Revenue Service requirements for such arrangements. However, if laws change or if this arrangement does not satisfy those requirements, I understand the tax advantages described for this plan may not be available. I further understand that making pretax contributions could slightly reduce my future Social Security benefits.

I understand that changes can not be made until the next open enrollment unless one of the below events occur:

-Change in status (employee's legal marital status, number of dependents, employment status – including change in worksite location, dependent satisfies eligibility requirements, change in residence, commencement/termination of adoption proceedings)
- Significant cost increase
- Significant curtailment of coverage
- Addition or elimination of benefit package option
- Change in coverage of spouse or dependent under other employer's plan
- FMLA leave
- COBRA event
- Judgment, decree or court order
- Medicare or Medicaid entitlement

Premium Conversion Plan. Unless you decline this option, you will pay for your dental coverage with pretax dollars. This means your contributions toward coverage will be taken out of your paycheck before Social Security or federal income tax dollars are calculated. If you don't want to pay for your medical coverage on a pretax basis, check the box on the front. The election you make now will remain in effect during this and all subsequent plan years until you change your election during a future open enrollment.

Domestic Partner Coverage:
Please note that most domestic partners do not qualify as tax dependents, and as such, premium amounts that you pay for domestic partner coverage will not occur on a pre-tax basis unless you submit evidence of tax dependency. In addition, the portion of the domestic partner premium that the company pays for is required to be included on your W-2 as imputed income, and is subject to taxation accordingly.

Confidential Data:
The carrier is responsible for confidential data. State and Federal law assures that private health information will be held confidential.

RCW 48.135.080:
"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

Standard Release of Information Provision (HIPAA Disclosure & Privacy:
I authorize any source to release to [Regence BlueShield of Idaho / the issuer], any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that [Regence BlueShield of Idaho / the issuer] may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

a physician, dentist, pharmacist or other physical or behavioral health care practitioner;

a clinic, hospital, long term care or other medical facility;

any other institution providing care treatment, consultation, pharmaceuticals or supplies;

or an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Underwritten by:
Regence BlueShield of Idaho
1602 21st Avenue
Lewiston, Idaho 8350

Form # Custom App/Enr Clarkston School District 2011-12.