Employee Benefits Enrollment Form

Unified Insurance Program

A. GENERAL EMPLOYEE INFORMATION

Last Name:	**First Name:**	**Middle Initial:**	**Employment Date:**	**Employee ID. No.**
Job Title:	**Department:**		**Benefit Eligibility Date:**	**SSN:** **Gender:**
Birth Date:	**Status (**Married, Domestic Partner, or Single**):** Single			**Date of Marriage:**
Home Address:	**City:**	**State:**	**Zip:**	**Home Phone:**
Mailing Address:	**City:**	**State:**	**Zip:**	**Home Email:**

B. COVERAGE INFORMATION

☐ New Employee ☐ Qualifying Event ☐ Open Enrollment	☐ Name Change ☐ Address Change Effective Date:_____	Is the change a COBRA Event? ☐ Yes ☐ No	What is the Qualifying Event?	What is the Date of Qualifying Event?

Medical & Vision Provider (Group No. 100000030)	**Dental Provider (Group No. 00755)**	**Life/AD&D & Disability Provider (Group No. 166103)**
PREMERA BLUE CROSS	DELTA DENTAL	RELIANCE STANDARD LIFE INSURANCE COMPANY A MEMBER OF THE TOKIO MARINE GROUP

PLAN, LEVEL AND COVERAGE ELECTIONS

Medical Plan Election: ☐ **PPO Plan** ☐ **CDHP Plan**				
Medical Plan Level:	Employee Only ☐	Employee+Spouse: ☐	Employee+Child(ren): ☐	Employee+Family: ☐
Dental Plan Level:	Employee Only ☐	Employee+Spouse: ☐	Employee+Child(ren): ☐	Employee+Family: ☐
Vision Plan Level:	Employee Only ☐	Employee+Spouse: ☐	Employee+Child(ren): ☐	Employee+Family: ☐

Relationship to Employee	**Medical Plan Election**	**Dental Plan Election**	**Vision Plan Election**	**Last Name, First, Initial**	**Birth Date**	**Gender**	**SSN**
	Enroll **(E)**/ Delete **(D)** /Change Personal Information **(C)** / No Change **(NC)** / Order ID Card **(ID)**						
Employee	E (Enroll)	E (Enroll)	E (Enroll)				
Spouse/Domestic Partner	NA (Not Applicable)	NA (Not Applicable)	NA (Not Applicable)				
Child*	NA (Not Applicable)	NA (Not Applicable)	NA (Not Applicable)				
Child*	NA (Not Applicable)	NA (Not Applicable)	NA (Not Applicable)				
Child*	NA (Not Applicable)	NA (Not Applicable)	NA (Not Applicable)				
Child*	NA (Not Applicable)	NA (Not Applicable)	NA (Not Applicable)				
Child*	NA (Not Applicable)	NA (Not Applicable)	NA (Not Applicable)				

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LONG TERM DISABILITY (LTD) - Reliance Standard Policy No. 134069

Automatic Enrollment	**Core LTD Coverage 60% to $6,300 monthly maximum**	**$0.295 per $100 gross base wages**
Optional Enrollment	**Buy-Up LTD Coverage to 66 2/3% to $10,000 monthly maximum**	**$0.515 per $100 gross base wages**
LTD Coverage Election: Enroll in Buy-up Coverage: ☐ Decline Buy-up Coverage: ☐		

NOTE: No coverage provided during the first 12 months for pre-existing conditions experienced 3 months prior to effective date of coverage. See benefit booklet for more details.

LIFE INSURANCE/ACCIDENTAL DEATH & DISMEMBERMENT (PUD Paid) - Reliance Standard Policy No. 166103

Automatic Enrollment	**Benefit equals 1x Annual Earnings** *Apply for Supplemental Life on separate enrollment form

All benefit eligible employees are enrolled in this plan at the time they become eligible. Beneficiary designations for this plan are made on a separate form, please see HR if you would like to review or update your beneficiaries for this Plan.

C. OTHER COVERAGE INFORMATION

If you or any dependent(s) applying for coverage, have coverage with any health care plan now or in the 3 month period before your enrollment date, complete the following. Please also complete a Premera "Other Coverage Questionnaire" form.

Do you have other Medical Coverage: ☐ Yes ☐ No Will this coverage remain in place after enrollment on this plan? ☐ Yes ☐ No	Do you have other Dental Coverage: ☐ Yes ☐ No Will this coverage remain in place after enrollment on this plan? ☐ Yes ☐ No	Is anyone in your family enrolled in a Medicare Plan: ☐ Yes ☐ No Which Plans (check all that apply): Plan A ☐ Plan B ☐ Plan D ☐
Medical Insurers Name:	Dental Insurers Name:	Date Coverage Began: / Date Coverage Ends:
Date Coverage Began: / Date Coverage Ends:	Date Coverage Began: / Date Coverage Ends:	Who is covered under the above Medicare Plan(s)?
Medical Policy/ Subscriber/ Group Numbers:	Dental Policy/ Subscriber/ Group Numbers:	**If you have a child who will be covered under the District's medical/dental plans and do not live with you, please provide us with the name and address of the custodian.** **Name (first, last):**_____ **Address:** _____ **Is the custodian financially responsible according to court documents?** ☐ Yes ☐ No
Who is covered under this Medical plan?	Who is covered under this Dental plan?	

D. EMPLOYEE SIGNATURE

I hereby apply for enrollment and make the elections as indicated on this application. I understand that my elections will remain in place and that I cannot change them until the end of the Plan Year unless I have a qualifying event that allows a change. I agree to and authorize deductions from my wages to pay my portion of the cost of the benefits I have elected above. With the exception of long-term disability insurance premiums, I understand that the deductions from wages will be on a pre-tax basis unless I affirmatively elect to pay the cost of these benefits on an after-tax basis. In order to elect to pay the cost of the benefits on an after-tax basis, I understand I must contact my Human Resources Department. I give permission for the Plan to examine records pertaining to my covered family members and me as required to process claims. I authorize any person, organization, or insurance company to furnish or obtain from the Plan any information regarding benefits to which I may be entitled. I understand that it is fraudulent to knowingly provide false, incomplete or misleading information to the Plan and I understand that if I do so, my family and I may become ineligible for the Plan and that I may face employment-related disciplinary action. I understand that I must promptly inform my Human Resources Department when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. Failure by me to provide timely notification may result in me being liable for claims and premiums paid by the employer for ineligible dependents. I certify the information on this form is true, correct and complete. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offset.** Changes in coverage are allowed only in accordance with the terms described in the CWPU UIP Benefit Booklets.

Employee Signature: _____ **Date: _____**

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DEFINITIONS & ACCEPTABLE SUPPORTING DOCUMENTATION FOR ENROLLING DEPENDENTS

Unified Insurance Program

E. ENROLLING DEPENDENTS: DEFINITIONS

Spouse/Domestic Partner:

- The lawful spouse of the subscriber, unless legally separated. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction.)
- The domestic partner of the subscriber, who is in a registered domestic partnership with the subscriber.

All rights, benefits and obligations afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."

Child under age 26:

- A natural offspring of either or both the subscriber or spouse
- A legally adopted child of either or both the subscriber or spouse
- A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
- A legally placed dependent or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
- A dependent child age 26 or older incapable of self-support due to a developmental or physical disability that occurred before age 26 may be an eligible dependent when the child is chiefly dependent upon the subscriber for support and maintenance. A Disabled Dependent Certification form must be completed and submitted through the group. The group must approve the request for certification before coverage can become effective.

Please contact your Group's Human Resources (HR) department regarding subscriber/dependent enrollment procedures and documentation requirements.

E. ENROLLING DEPENDENTS: ACCEPTABLE SUPPORTING DOCUMENTATION

Spouse/Domestic Partner Proof of Relationship (any one of the following documents):

- Copy of the first page of the prior tax year's Married Filing Jointly federal income tax return that indicates this spouse (black out financial information and any dependent's social security number); or
- Copy of the first page of subscriber's and spouse's prior tax year's Married Filing Separately federal income tax returns (black out financial information and any social security number)

- Copy of legal marriage certificate (or license), or copy of domestic partner registration; **and** proof of common residency (such as a utility bill)
- Copy of legal marriage certificate (or license), or copy of domestic partner registration; **and** proof of financial interdependency (such as a shared bank statement – black out financial information)
- Copy of presently valid affidavit or declaration of Common Law Marriage from any State that recognizes, and proof of financial interdependency (such as a shared bank statement—black out financial information)

NOTE: *Domestic Partners must also provide a Declaration of Partner's/Partner's Children's Tax Status form*

Child under age 26 Proof of Relationship (any one of the following documents):

- Copy of page 1 of the prior year's federal tax return that includes the child as a dependent (black out financial information and any dependent's social security number). Note: Not sufficient proof for legal guardianship. Additional proof required-see bullet #5 below.
- Copy of birth certificate showing the name of the parent who is the subscriber or the subscriber's spouse/domestic partner
- Copy of certificate or decree of adoption showing the parent/child relationship with the subscriber or the subscriber's spouse/domestic partner
- Copy of official court order (divorce decree/custody agreement) showing the parent/child relationship with the subscriber or the subscriber's spouse/ domestic partner
- Copy of legal guardianship papers issued by the courts showing the guardian/child relationship with the subscriber or the subscriber's spouse/ domestic partner
- Copy of a Qualified Medical Child Support Order (QMCSO)
- Copy of court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date

SPECIAL REQUIREMENTS FOR CHILDREN OF YOUR LEGAL SPOUSE OR DOMESTIC PARTNER: If you are a subscriber providing documentation for a child of your legal spouse/domestic partner, documentation must also include any one of the documents listed for spouse/domestic partner.

Disabled Children 26 and over:

Proof of Relationship, Financial Responsibility and Disability (the following sets of documents):

- Any one of the documents or sets of documents listed above for Child under age 26 demonstrating parent/child relationship and financial dependency or residency; **AND**
- A Premera and Delta Dental "Disabled Dependent Certification" form must be completed and submitted for review and approval. These forms require Physician statements certifying that the dependent child is incapable of self-sustaining employment due to a mental or physical disability that began prior to age 26.