



SE POLK COMMUNITY SCHOOLS Healthcare Enrollment Form

NOTE: UPON COMPLETION, THIS FORM REPLACES ANY AND ALL PREVIOUS ENROLLMENT FORMS

GROUP NUMBER 90400

EMPLOYEE INFORMATION	
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH
SOCIAL SECURITY NUMBER	
STREET/MAILING ADDRESS	
CITY, STATE, ZIP	SEX
HOME PHONE NUMBER	
MARITAL STATUS: <input type="checkbox"/> -SINGLE <input type="checkbox"/> -MARRIED <input type="checkbox"/> -DIVORCED <input type="checkbox"/> -WIDOWED	DATE OF FULL TIME EMPLOYMENT

MEDICAL COVERAGE REQUEST: <input type="checkbox"/> -EMPLOYEE/SINGLE <input type="checkbox"/> -FAMILY
I <u>DECLINE</u> MEDICAL COVERAGE FOR: <input type="checkbox"/> -MYSELF AND MY ELIGIBLE DEPENDENTS <input type="checkbox"/> -MY SPOUSE <input type="checkbox"/> -MY DEPENDENTS (COMPLETE BACK OF FORM)

DEPENDENT INFORMATION: PLEASE COMPLETE FOR ALL DEPENDENTS COVERED BY THIS REQUEST						DOES DEPENDENT HAVE OTHER COVERAGE? IF SO, LIST INSURANCE CO. NAME
DEPENDENT NAME (FIRST AND LAST)	SEX M/F	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY #		
SPOUSE		SPOUSE				
1.						
2.						
3.						
4.						
(LIST ADDITIONAL CHILDREN ON AN ATTACHED SHEET.) ATTACH COPIES OF LEGAL COURT CUSTODY DECREES OR QUALIFIED MEDICAL CHILD SUPPORT ORDER						
ARE ANY DEPENDENTS AGE 19 AND OVER ATTENDING SCHOOL ON A FULL TIME BASIS? <input type="checkbox"/> -YES <input type="checkbox"/> -NO (A LETTER FROM THE REGISTRAR CONFIRMING FULL TIME STUDENT STATUS MUST BE PROVIDED BEFORE COVERAGE BEGINS.)						
DEPENDENT NAME/SCHOOL			DEPENDENT NAME/SCHOOL			

SPOUSE INFORMATION: COMPLETE ONLY IF REQUESTING COVERAGE FOR SPOUSE		IS SPOUSE EMPLOYED?	<input type="checkbox"/> -YES <input type="checkbox"/> -NO
SPOUSE'S EMPLOYER (COMPANY NAME)	EMPLOYER ADDRESS (CITY, STATE, ZIP)		
DOES YOUR SPOUSE HAVE GROUP MEDICAL INSURANCE THROUGH HIS/HER EMPLOYER? <input type="checkbox"/> -YES <input type="checkbox"/> -NO			
IF YES, <input type="checkbox"/> -SINGLE <input type="checkbox"/> -FAMILY EFFECTIVE DATE OF COVERAGE:			
IS ANY DEPENDENT OR SPOUSE DISABLED? <input type="checkbox"/> -YES <input type="checkbox"/> -NO (QUESTION ASKED FOR COORDINATION OF BENEFITS INFO ONLY)		NAME OF DISABLED DEPENDENT	TYPE OF DISABILITY/DATE DISABILITY BEGAN

IMPORTANT NOTICE

PLEASE CAREFULLY REVIEW AND SIGN THE REVERSE SIDE.

YOUR SIGNATURE IS REQUIRED BEFORE THIS FORM CAN BE PROCESSED !!



---- EMPLOYER USE ONLY -- PLEASE COMPLETE ----				
<input type="checkbox"/> -NEW EMPLOYEE				
CHANGE: (CHECK ONE) <input type="checkbox"/> -SPECIAL ENROLLEE <input type="checkbox"/> -LATE APPLICANT <input type="checkbox"/> -COBRA <input type="checkbox"/> -RETIREE <input type="checkbox"/> -OTHER				
➤ PLEASE EXPLAIN CHANGE AND DATE OF "QUALIFYING" EVENT AND EMPLOYEE/DEPENDENT NAMES, IF APPLICABLE:				
CLASSIFICATION: <input type="checkbox"/> -CLASSIFIED <input type="checkbox"/> -CERTIFIED		PPO: <input type="checkbox"/> -HSM <input type="checkbox"/> -SELECT FIRST 2000 <input type="checkbox"/> -SELECT FIRST 2009		
MEDICAL COVERAGE : <input type="checkbox"/> -EMPLOYEE/SINGLE <input type="checkbox"/> -FAMILY <input type="checkbox"/> -DECLINE MEDICAL				
HIRE DATE	ELIGIBILITY DATE	ORIGINAL EFFECTIVE DATE OF MEDICAL COVERAGE	EFFECTIVE DATE OF CHANGE	EMPLOYER AUTHORIZED SIGNATURE
PRIOR CREDITABLE COVERAGE REQUEST:				
<input type="checkbox"/> -CERTIFICATE ATTACHED		<input type="checkbox"/> -CERTIFICATE TO FOLLOW		<input type="checkbox"/> -NO PRIOR CREDITABLE COVERAGE (NO CERTIFICATE)

SOUTHEAST POLK COMMUNITY SCHOOL DISTRICT

IMPORTANT INFORMATION: PLEASE READ AND SIGN BELOW

HEALTHCARE PREEXISTING CONDITION; SPECIAL ENROLLMENT PROVISION, DECLINATION AND CONTACT INFORMATION

PREEXISTING CONDITION EXCLUSION RULES FOR LATE ENROLLEES:

This plan imposes a preexisting condition exclusion for **late enrollees**. That means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan or who has creditable coverage within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

SPECIAL ENROLLMENT PROVISION

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Medicaid or SCHIP: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while on Medicaid or SCHIP you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after you or your dependents lose that coverage.

Dependent Beneficiaries

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. In addition, if you have a new dependent as a result of marriage you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage. In addition, if you have a new dependent as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after the birth, adoption, or placement for adoption.

Eligibility for Premium Assistance under Medicaid or CHIP.

If the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP), you may be able to enroll yourself and your eligible dependents. You must request enrollment within 60 days.

DECLINATION OF COVERAGE

Open enrollment will be held annually during the month of June with a July 1 effective date.

I have been given the opportunity to participate in the group healthcare plan offered by my employer and I decline participation for:

- Myself And My Eligible Dependents: Names: _____
 My Eligible Dependents: Names: _____

Reason For Declining Coverage (Check One):

- Currently Covered Under Another Medical Benefit Plan
 Other _____

IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.

CONTACT INFORMATION

All questions about the preexisting condition exclusion and creditable coverage should be directed to Membership Representative, First Administrators, Inc., PO Box 9900, Sioux City, IA 51102-0479 or phone 1-800-206-0827.

ASSIGNMENT AND AUTHORIZATION

ASSIGNMENT: I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PROVIDER OF SERVICE BY MY EMPLOYER'S HEALTHCARE PLAN HEREIN NAMED OF THE GROUP BENEFIT'S PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE, TO OR BY FIRST ADMINISTRATORS, INC. OF ANY HOSPITAL, MEDICAL, OR OTHER INSURANCE INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. I HEREBY REQUEST THE AMOUNT(S) AND FORMS FOR COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE, AND HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS.

I HAVE READ AND COMPLETED ALL OF THE INFORMATION OUTLINED ABOVE

EMPLOYEE SIGNATURE

DATE SIGNED