NAPERVILLE COMMUNITY UNIT SCHOOL DISTRICT 203
GROUP INSURANCE ENROLLMENT FORM

ABOUT YOU – Please Print Information Clearly

Employee ID Number
Phone #
E-mail Address

Name

Social Security Number

☐ Male ☐ Female

Street Address

City/State/ZIP

Position and Job Location

Your Date of Birth
Mo. Day Yr.

Employment Date
Mo. Day Yr.

FAMILY STATUS ☐ Single ☐ Separated ☐ Divorced ☐ Married/Civil Union ☐ Widowed

COVERAGE ELECTIONS
Initial Choice:

District Medical/RX Options through BlueCross BlueShield Available for 1/1/2015

Check One: ☐ Platinum PPO ☐ Gold HDHP ☐ Silver PPO (all three include Delta Dental)

The Platinum PPO is the same as the current plan.

☐ I choose Single Health and Dental Coverage

☐ I choose Family Coverage Health and Dental Coverage (see reverse side)

☐ I choose Single Vision Coverage

☐ I choose Family Vision Coverage

You can only elect Vision Coverage for the same enrollment level (Single or Family) that you chose for Health/Dental

☐ I Do Not Want Group Health/Dental/Vision Coverage (see section below if you are declining district health insurance coverage)

For Family Coverage, please see reverse side

DECLINING HEALTH COVERAGE (Only check & sign here if you ARE DECLINING Health coverage)

If you are declining enrollment in Health coverage for yourself and/or eligible dependents at this time, please check the appropriate reason(s) listed below and the individuals it applies to:

☐ Covered under another employer's group plan as an employee (see Other Insurance chart on reverse side)
____ *Self* ____ *Spouse/Civil Union Partner* ____ *Dependent Child(ren)*

☐ Covered under another employer's group plan as a spouse/civil union partner or dependent (see Other Insurance chart on reverse side)
____ *Self* ____ *Spouse/Civil Union Partner* ____ *Dependent Child(ren)*

☐ Covered by Medicare, Veterans Program or non-group coverage – including insurance purchased through the Marketplace/Exchange (see Other Insurance chart on reverse side)
____ *Self* ____ *Spouse/Civil Union Partner* ____ *Dependent Child(ren)*

☐ Do not wish to participate in health care benefits (declining health insurance entirely)
____ *Self* ____ *Spouse/Civil Union Partner* ____ *Dependent Child(ren)*

I DO NOT wish to request health/dental/vision coverage under the Group Plan offered by my employer. I realize that I will not receive any additional compensation by declining this coverage. I acknowldege that the health insurance offered by my employer is intended to be both affordable and meet minimum value, as defined by the Affordable Care Act, and that as such, I may not be entitled to subsidies under the Health Insurance Marketplace (Exchange) unless I qualify for Medicaid. If an employee declines coverage for him/herself or any dependents (including a spouse/civil union partner) because of other health insurance coverage, the employee may, in the future, enroll him/herself and any dependents in this plan, provided that enrollment is requested within 31 days of an IRS recognized life change event including involuntary loss of other coverage, marriage, civil union, divorce, spouse's death, birth of a dependent, adoption or placement for adoption.) Employee Signature _____

LIFE INSURANCE BENEFICIARY INFORMATION

Name, Relationship and Social Security Number of Beneficiary

Secondary Beneficiary (if desired)

ACKNOWLEDGEMENT: I hereby agree that I shall be insured for the group benefits for which I am now (or may later become) eligible under my employer's group plan. I authorize the deduction by my employer from my earnings of the amount, if any, of contributions required of me for such benefits. I understand that I may not alter my elections during the policy year without a qualifying life change. The policy year begins January 1st. I certify that all information provided above is accurate, current and complete to the best of my knowledge. *Note: The law provides for severe penalties for any person who willfully, knowingly and with intent to defraud or deceive, files false, incomplete or misleading insurance information.*

I elect to have my insurance deduction from my ☐ pre-tax income ☐ after tax income (required for civil union partner)

Signature _____ Date _____

OTHER INSURANCE

If you or your eligible dependents are enrolled in other insurance coverage, please fill out the following:

BENEFIT *(Health, Dental, or Vision)*	**INSURANCE CO.**	**POLICY NO.**	**OFFERED THROUGH** *(Employer's Name)*	**APPLIES TO** *(Self, Spouse/Civil Union Partner, and/or Dependent Child)*

DEPENDENT INFORMATION

(You will be required to submit proof of Dependent Eligibility.)

If you enroll for **FAMILY COVERAGE**, please print the first name and the middle initial (and last name if different from your own) along with relationship and date of birth for each eligible dependent. You must include social security numbers. Spouse/Civil Union Partners are considered dependents.

Enrollment in Naperville Community Unit School District 203's **FAMILY** Health Care Plan requires proof of dependent eligibility. Eligible dependents include spouse/civil union partners, biological children, adopted children, and children of whom you have legal guardianship. All dependent children must be under age 26. You will be required to provide the following documents, as applicable, to the Employee Benefits Coordinator in the Business Office along with your enrollment form: A copy of your Marriage/Civil Union Certificate or a copy of your most recent joint federal tax return; a copy of the Birth Certificate, Adoption Certificate or Court Order for each dependent to be covered under the plan, (excluding your spouse) and a Spousal/Civil Union Partner Coverage Election and Disclosure Form.

NAME	**SOCIAL SECURITY NO.**	**RELATIONSHIP**	**DATE OF BIRTH**

EMPLOYER USE ONLY

☐ New Employee ☐ Special Enrollee ☐ Open Enrollment ☐ Single to Family ☐ Other _____
(marriage, divorce, dissolution, birth, address change, etc.)

Effective Date _____ Class _____ Union _____

☐ 26 pays ☐ 20 pays ☐ Wellness Credit ☐ Spousal Surcharge Spousal Surcharge $_____

Premium amount $_____ Vision _____ Notes: _____

Voluntary Deductions _____

Payroll premiums to start _____ Premium Adjustment _____ Option _____

Enrolled: Medical/RX Plan _____ Dental _____ Vision _____

Revised: 11/10/2014 kb/ap