2019-2020 BENEFIT ENROLLMENT FORM

ALL BENEFIT ELECTIONS/CHANGES WILL BE EFFECTIVE JULY 1, 2019

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SEC NUMBER
ADDRESS	APT #	CITY	STATE	ZIP
PRIMARY PHONE	GENDER MALE ☐ FEMALE ☐	MARITAL STATUS	EMAIL ADDRESS	

SELECTION OF MEDICAL PLAN

	Option 1 - H.S.A	Option 2 - Flexpoint	Option 3 - PPO	
Employee Only	☐	☐	☐	
Employee & Spouse	☐	☐	☐	WAIVE ALL MEDICAL ☐
Employee & Child(ren)	☐	☐	☐	
Employee & Family	☐	☐	☐	
Family Team	☐	☐	☐	

(Both spouses are full time employees of the R3 District))

SELECTION OF DENTAL PLAN

	Base	Buy Up	
Employee Only	☐	☐	
Employee & Spouse	☐	☐	WAIVE ALL DENTAL ☐
Employee & Child(ren)	☐	☐	
Employee & Family	☐	☐	

SELECTION OF VISION PLAN

	Option 1		
Employee Only	☐		
Employee & Spouse	☐		WAIVE ALL VISION ☐
Employee & Child(ren)	☐		
Employee & Family	☐		

WAIVER OF COVERAGE

I understand that by marking above and signing below, I am waiving one or more coverages at this time. I understand that I am waiving Medical, Dental and /or Vision coverage and will not be allowed to participate unless I qualify at a special enrollment period, if applicable, or at the next open enrollment period. By waiving these coverages I am forfeiting the amount of premiums the District contributes as part of my overall compensation, and understand this will also effect my PSRS/PEERS retirement contribution amounts. I also understand that if I do not obtain medical coverage elsewhere, I may be subject to an IRS penalty under the Affordable Care Act.

Employee Signature: _____ Date _____
(signature for waiver of coverage ONLY)

OTHER MEDICAL COVERAGE INFORMATION (INCLUDING MEDICARE)

As of your effective date will you, your spouse, or any of your dependents be covered under any other medical health plan?

NAME OF OTHER CARRIER:

Please list each individual which will be covered by any additional medical health plan or policy as of 7/1/2019.

SELF ☐	NAME:
SPOUSE ☐	NAME:
CHILDREN ☐	NAME(s):

FAMILY INFORMATION

LIST ALL **DEPENDENTS** THAT YOU ARE COVERING ON MEDICAL, DENTAL, and/or VISION.

	LAST NAME	FIRST NAME	MI	RELATIONSHIP
☐ ADD				
☐ DROP	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐	SOCIAL SECURITY NUMBER	
	☐ Medical	☐ Dental	☐ Vision	

	LAST NAME	FIRST NAME	MI	RELATIONSHIP
☐ ADD				
☐ DROP	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐	SOCIAL SECURITY NUMBER	
	☐ Medical	☐ Dental	☐ Vision	

	LAST NAME	FIRST NAME	MI	RELATIONSHIP
☐ ADD				
☐ DROP	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐	SOCIAL SECURITY NUMBER	
	☐ Medical	☐ Dental	☐ Vision	

	LAST NAME	FIRST NAME	MI	RELATIONSHIP
☐ ADD				
☐ DROP	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐	SOCIAL SECURITY NUMBER	
	☐ Medical	☐ Dental	☐ Vision	

	LAST NAME	FIRST NAME	MI	RELATIONSHIP
☐ ADD				
☐ DROP	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐	SOCIAL SECURITY NUMBER	
	☐ Medical	☐ Dental	☐ Vision	

SIGNATURE OF EMPLOYEE

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually indentifiable and use it for commercial and other purposes.

Employee Signature ______________________________ Date ______________

SECTION 125 SALARY REDIRECTION AGREEMENT

I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Health Savings Account (HSA) and Flexible Spending Account(s) (FSA) election amount(s) will be deducted from my paycheck by my employer. Unless this agreement is amended or terminated by my employer, these deductions will be continuous for the entire plan year ending on June 30, 2020, on a monthly basis, and in an amount equal to my required contribution for my elected coverage and/or HSA and FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution will be provided to me prior to the first deduction. Amounts corresponding to employer-provided benefits will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased.

I consent to having medical, dental, vision HSA, and FSA amounts, as elected, deducted on a pre-tax basis.

Employee Initials ______________ **Date** ______________

PAYROLL DEDUCTIONS

I understand that my first paycheck may have double deductions.

I also understand that if a paycheck is not received, the employee may owe the amount due to cover any premiums that are not normally paid by the District. Any premiums owed to the District are due to the Business & Finance Ofice on or before the 5th of the month prior to coverage.

Employee Initials ______________ **Date** ______________