

INSURANCE BENEFITS ENROLLMENT/CHANGE FORM

Read all Plan Summaries before completing this form. This form is for BVSD benefit eligible employees enrolling in **medical and / or dental** coverage OR making changes to their existing coverage. Please use a pen to complete each section, **sign the form**, and return it to Human Resources.

6500 Arapahoe, PO Box 9011
Boulder, Colorado 80301
303-447-5031
<http://www.bvsd.org>

Section 1: Action

<input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REINSTATE <input type="checkbox"/> CANCEL ALL COVERAGE				EFFECTIVE DATE (MM/DD/CCYY) _____/_____/_____			
ENROLLMENT FOR: <input type="checkbox"/> Myself <input type="checkbox"/> Myself & my spouse <u>OR</u> child <input type="checkbox"/> Myself & my children <input type="checkbox"/> Myself & my family		PLAN SELECTION: Medical Great West STANDARD PPO <input type="checkbox"/> Ee+ <input type="checkbox"/> 1 Dep <input type="checkbox"/> Ee+ <input type="checkbox"/> Children <input type="checkbox"/> Ee+ <input type="checkbox"/> Fam Great West BASIC PPO <input type="checkbox"/> Ee <input type="checkbox"/> 1 Dep <input type="checkbox"/> Ee+ <input type="checkbox"/> Children <input type="checkbox"/> Ee+ <input type="checkbox"/> Fam KAISER Plan 220 <input type="checkbox"/> Ee <input type="checkbox"/> 1 Dep <input type="checkbox"/> Ee+ <input type="checkbox"/> Children <input type="checkbox"/> Ee+ <input type="checkbox"/> Fam		Dental Delta Dental - PPO <input type="checkbox"/> Ee <input type="checkbox"/> 1 Dep <input type="checkbox"/> Ee+ <input type="checkbox"/> Children <input type="checkbox"/> Ee+ <input type="checkbox"/> Fam		CHANGING INFORMATION: <input type="checkbox"/> Updating general information <input type="checkbox"/> Transferring to a different plan <input type="checkbox"/> Adding a dependent <input type="checkbox"/> Deleting a dependent Reason for change: _____	

Section 2: About You

Employee Name (Last / First / MI)		Sex	Social Security No.	Position / School or Department	
Employee Date of Birth (MM/DD/CCYY)	Home Phone	Work Phone		Date of Hire	
Home Address (Street)			City	State	Zip Code

Section 3: List Dependents

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No.	Coverage Selection	Check one
Spouse						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete

Section 4: Conditions for Enrollment

The information provided above is true and correct to the best of my knowledge. I authorize any health care provider, insurance company, or other organization, institution, or person that has any information regarding my benefit eligibility or claims to release such information to the claims administrator. A copy of this authorization shall be considered as effective and valid as the original. I understand that any misrepresentation on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable. I understand that if I later apply for coverage I am currently waiving, pre-existing conditions exclusions and other limitations may apply. If I have declined any of the above-listed coverages, I understand that I will not be covered for these group plan benefits for which I am eligible. I understand that I may have to submit evidence of insurability if I want these coverages at a later day. I authorize Boulder Valley School District to reduce my pre-tax pay to pay for the medical coverage benefits I have elected. I understand I am required to fill out a district "opt-out" form to have these deductions taken after-taxes and submit it along with this enrollment form.

I further authorize Boulder Valley School District to continue these pre-tax or after-tax payroll deductions until such time as I elect to change or stop such elections.

Employee Signature	Date	Employer Signature	Date
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DISCLOSURE INFORMATION

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "Special Applicant" if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated involuntarily; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption of a child. I understand that to qualify as a "Special Applicant" I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:
- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a "Special Applicant" because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

This Disclosure Information forms a part of the Application for Membership as fully as if it were contained over the applicant's signature.



Coordination of Benefits

I hereby authorize Kaiser Permanente to bill my spouse's or any other dependent's primary group insurance carrier for all services provided or arranged by Participating Physicians and to coordinate benefits and/or reimbursements with other health or insurance companies. I request that payment be made to Kaiser Permanente on any bills for services furnished for myself or any dependents on my plan. I also authorize Kaiser Permanente to release any information regarding the medical treatment needed for this claim. I further authorize this copy to be used in place of the original.

Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make healthcare decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes: CRS 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive and will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A healthcare provider or healthcare facility shall provide for the prompt transfer of the principal to another healthcare provider or healthcare facilities if such healthcare provider or healthcare facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (CRS 15-14-507)

Two brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call the Customer Service at 303-338-3800.

Terms and Conditions

I expressly authorize any doctor or hospital to furnish Kaiser Permanente any records concerning me or any other member of my family.

To the best of my knowledge, the information I have provided is complete and true and I understand that falsification by me will allow Kaiser Permanente to recover payments made, cancel my membership and/or refuse to pay claims.

I hereby apply for enrollment for myself and my eligible family dependents listed. I understand that if this application is accepted by Kaiser Permanente, the benefits for which we will be eligible will be in accordance with the master contract applicable to the type of plan for which we are enrolled.

I authorize payroll deduction for whatever amounts are necessary to pay my health plan coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.