Davis School District
45 East State Street, P. O. Box 588, Farmington, UT 84025-0588

Insurance Enrollment Form

The Davis School District collects this information to process personnel and payroll actions. Your failure to provide the requested information could jeopardize your opportunity for employment with the district. Private and controlled information is shared or received according to the requirements under GRAMA.

A. EMPLOYEE INFORMATION

Legal Last Name	*First Name*	*Middle Name or MI*	*Social Security Number*	*Gender*	*DOB (month/day/year)*
			— —		/ /

Address	*City*	*State*	*Zip Code*	*Telephone Number (Include Area) Code*
				( )

Marital Status ☐ Single ☐ Married

Location of Employment

If your spouse is a district employee and carrys the health plan, please choose one option for your health enrollment:

◯ Coordinate health with my spouse.
◯ Enroll me with my own individual health plan.

_____
Name of district employed spouse

B. DEPENDENT(S) INFORMATION *(also required for dependent basic life insurance enrollment)*

***Relations:** **SP**=Spouse; **CH**=Child; **AD**=Adopted; **LG**=Legal Guardianship; **SC**=Step Child

Social Security #	Legal First Name, Middle Name or MI, Last Name	*Relation	M/F	DOB *(month/day/year)*

(Additional dependents may be listed on a separate paper and attached it to the insurance Enrollment Form.)

C. HEALTH PLANS AND COVERAGE

PLAN CHOICE (Check One)

☐ DECLINE District Health Insurance
☐ AETNA Select Open Access *#737435-012-0001-002*
☐ AETNA Select Open Access High Deductible (Form A)
Single: #37435-010-00001-00100 2-plus: #373435-010-00001-10200
☐ SHC SelectMed *#G1007099-1008-F30A6000*
☐ SHC SelectMed High Deductible (Form B)
Single: #G1007099-1008-F30A6500 2- plus: #G1007099-1008-F30A6501

COVERAGE CHOICE (Check One)

◯ Employee Only
◯ Employee + Spouse
◯ Employee + Child*_____
*Name of single covered child.
◯ Employee + Children
◯ Employee + Spouse + Child(ren)

D. DENTAL PLANS AND COVERAGE

PLAN CHOICE (Check One)

☐ DECLINE Dental Insurance
☐ DELTA DENTAL BASIC PPO *#03310-01001*
☐ DELTA DENTAL PREMIER PLUS PPO *#03310-02001*

COVERAGE CHOICE (Check One)

◯ Employee Only
◯ Employee + Spouse
◯ Employee + Child*_____
*Name of single covered child.
◯ Employee + Child(ren)
◯ Employee + Spouse + Child(ren)

E. VOLUNTARY VISION CARE AND COVERAGE

OPTICARE "120B" *(Check One)*

Employee pays full cost for this benefit.

☐ NO. Decline Enrollment
☐ YES. Enroll me on the Opticare plan.

COVERAGE CHOICE (Check One)

◯ Employee Only
◯ Employee + Spouse
◯ Employee + Child*_____
*Name of single covered child.
◯ Employee + Children
◯ Employee + Spouse + Child(ren)

PLEASE COMPLETE BOTH SIDES

F. BASIC LIFE INSURANCE BENEFICIARIES

THE HARTFORD BASIC LIFE INSURANCE

This is a district paid benefit at not cost to the employee and dependent(s). It is the employee's one time annual base salary to a maximum of $150,000 and $3,000 for eligible dependents. For dependents to receive this benefit, they must be listed in Section B in the front of the form The employee is the automatic beneficiary for the dependent benefits.

Beneficiaries	Social Security #	Rel*	DOB	Address (City, State, Zip Code, Country)
PRIMARY				
CONTINGENT				

*Relation: **AU**=Aunt; **BR**=Brother; **CH**=Child; **CR**=Children; **FR**=Friend; **NE**=Nephew; **NI**=Niece; **OT**=Other; **PR**=Parent; **SS**=Sister; **SP**=Spouse;**TR**=Trust; **UN**=Uncle

G. *EMPLOYEE ONLY* ACCIDENTAL DEATH AND DISMEMEBERMENT INSURANCE: *Premium cost is two cents ($ .02) per $1,000*

THE HARTFORD ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The employee pays full cost for this benefit. This is available in $10,000 increment up to $500,000 guaranteed.

☐ I *decline* participation in the accidental death and dismemberment insurance.

☐ Enroll me for coverage amount of _____ *(Minimum of $10,000 up to $500,000)*

Beneficiaries	Social Security #	Rel*	DOB	Address (City, State, Zip Code, Country)
PRIMARY				
CONTINGENT				

H. SUPPLEMENTAL LIFE INSURANCE

THE HARTFORD SUPPLEMENTAL LIFE INSURANCE

You pay the full cost for this benefit. The guaranteed issue amount is $20,000 up to $500,000 for the employee, $20,000 up to $50,000 for the spouse and $5,000 or $10,000 for eligible dependent child(ren) if you enroll at your initial insurance eligibility date. Dependent children can enroll only if the employee is enrolled with supplemental life coverage. The employee is the automatic beneficiary for the spouse and child(ren) benefits.

☐ I *decline* participation in supplemental life insurance.

☐ EMPLOYEE coverage amount _____ ***($20,000 minimum up to $500,000 maximum in $10,000 increments)***

☐ SPOUSE coverage amount _____ ***($20,000 minimum up to $200,000 maximum and not greater than the employee amount)***

☐ CHILD(REN) *(Check One)* ◯ $5,000 ◯ $10,000

Beneficiaries	Social Security #	Rel*	DOB	Address (City, State, Zip Code, Country)
PRIMARY				
CONTINGENT				

(You may list more than one beneficiary on a separate paper and attach the list to the insurance enrollment form.)

I. *UNUM* LONG-TERM DISABILITY INSURANCE

The district contributes to the cost of long-term disability coverage. The LTD benefit is guaranteed if you enroll at your initial insurance eligibility date.

☐ I *decline* LTD enrollment.

☐ Enroll me in Long-Term Disability.

J. *UNUM* SHORT-TERM DISABILITY INSURANCE

You pay full cost for the short-term disability coverage. The STD benefit is guaranteed if you enroll at your initial insurance eligibility enrollment date.

☐ I *decline* STD enrollment.

☐ Enroll me in Short-Term Disability.

K. ACKNOWLEDGEME

This is to acknowledge the information regarding available coverages has been provided to me by my employer. I hereby apply for membership as indicated for the persons listed on this form. Where I have declined coverage, I understand that if I desire to apply for such insurance at some later date for myself and/or dependents, I will be a late entrant and plan restrictions may apply.

I represent the information is true and correct. I understand any misrepresentation provided on this application or nonpayment of premium fees, deductibles, co-insurance, or co-payments may result in the denial or cancellation of my coverage and that my dependents and I may be held financially responsible for related costs.

I understand this election is for the entire plan year and can only be changed during open enrollment or if I experience a change in family status. I understand written notification of family status changes must be provided to the District Insurance Office within 30 days of the event. My election in effect at the end of the plan year will remain in effect for the following plan year unless I change my election during the annual enrollment period or if a new election is required by the District.

I elect to have the required premiums payroll deducted pre-tax, except supplemental life and short and long term disability insurance.

I authorize any health care provider or insurance carrier to disclose to the plan or its representatives all information and records relating to diagnosis, treatment, medical history, and physical or mental conditions for which coverage by the plan is sought.

Employee Signature: _____ Date: _____