NCSD12 Multipurpose Form for :

Termination of Medical/Dental/Vision Insurance
Authorization to Stop Direct Deposit
Authorization to Stop Voluntary Deductions
Waiver of Group Health Coverage (see other side)

Rev 10/28/14

Employee # _____

_____ , _____
Employee Last Name | First Name

_____ _____
Phone and/or email address | Desired Effective Date

List Family Member(s) to be Removed from Coverage - Select ONLY coverage to be canceled

Employee/Subscriber	☐M ☐F	DOB	☐HMA Med ☐Kaiser Med ☐HMA Dent ☐Kaiser Dent ☐HMA Vis	Coverage Ends
Spouse / Domestic Partner	☐M ☐F	DOB	☐HMA Med ☐Kaiser Med ☐HMA Dent ☐Kaiser Dent ☐HMA Vis	Coverage Ends
Dependent 1	☐M ☐F	DOB	☐HMA Med ☐Kaiser Med ☐HMA Dent ☐Kaiser Dent ☐HMA Vis	Coverage Ends
Dependent 2	☐M ☐F	DOB	☐HMA Med ☐Kaiser Med ☐HMA Dent ☐Kaiser Dent ☐HMA Vis	Coverage Ends
Dependent 3	☐M ☐F	DOB	☐HMA Med ☐Kaiser Med ☐HMA Dent ☐Kaiser Dent ☐HMA Vis	Coverage Ends

Reason for Loss of Coverage (select one):

COBRA will be offered for 1-7 below

☐ 1 - Voluntary Termination of Employment (includes retirees)
☐ 2 - Involuntary Termination of Employment
☐ 3 - Reduced Hours
☐ 4 - Ineligible Dependent (age 26 for med/vis plans or Kaiser dent)
☐ 5 - Ineligible Dependent (age 25 for HMA dent)
☐ 6 - Divorce - Date decree certified by Court _____
☐ 7 - Legal Separation - Date certified by Court _____

HIPPA - COBRA will NOT be offered for 1-5
(If reason 1, 2, or 3 selected below, complete and sign Waiver of Coverage on reverse side)

☐ 1 - Elects to drop coverage (no alternate insurance)
☐ 2 - Benefits through another Carrier
☐ 3 - Elects to drop while on Leave Without Pay
☐ 4 - Entitled to Medicare Benefits
☐ 5 - Gross Misconduct

Direct Deposit, Standard Life & Disability Insurance, Supplemental Retirement, and Miscellaneous

☐ **Direct Deposit - Stop Completely**

Supplemental Retirement
It is the employee's responsibility to notify agent of this change.

☐ First Investors 403B ☐ Valic 403B ☐ Voya 403B
☐ First Inv 403B Roth ☐ Valic 403B Roth ☐ Voya 403B Roth
☐ First Investors 457 ☐ Valic 457 ☐ Voya 457
☐ Oppenheimer-First Inv ☐ Oppenheimer-Valic ☐ Oppenheimer-Voya

Standard Life & Disability

☐ Voluntary Life - Emp ☐ Basic Life - Emp ☐ Short Term Disab
☐ Voluntary Life - Spouse ☐ Basic Life - Spouse ☐ Long Term Disab
☐ Voluntary Life - Child ☐ Basic Life - Child

Miscellaneous

☐ NC Education Foundation ☐ United Way ☐ OSEA/ELAF Fund ☐ OSEA Life

_____ / / _____ / /
Employee Signature | Date | Benefits Specialist Authorization | Date

NCSD12 Multipurpose Form for :

Waiver of Group Health Coverage

Term of Med/Dent/Vis Insurance (see other side)

Authorization to Stop Direct Deposit (see other side)

Authorization to Stop Deductions (see other side)

Rev 10/28/14

Employee # _____

_____ , _____

Employee Last Name First Name

I acknowledge that I have been offered the opportunity to enroll in group health benefits available to me through my employer, North Clackamas School District (NCSD). These benefits include:

NC Medical Plan V, NC Vision, NC Dental, Kaiser Medical, and Kaiser Dental

I decline enrollment at this time for coverage provided through the District for:

☐ Medical ☐ Dental ☐ Vision (N/A if Kaiser Med enrolled)

Reason for declining coverage:

☐ I or my dependents **have other coverage** provided by:

Name of Insurance Carrier _____

Group -or- Policy Number _____

Group or Employer Name _____

List Covered Family members _____

_____

☐ I/we **do not have other coverage** but wish to waive benefits for:

☐ Myself ☐ Spouse/Domestic Partner

☐ Child/ren - List names _____

_____

Authorization Section

I understand if I decline enrollment for myself or dependents (including spouse/domestic partner) due to other health care coverage, I may enroll myself or my dependents on a NCSD plan prior to the next Open Enrollment period under a Qualifying Event. If I have involuntarily lost other coverage, NCSD must receive my enrollment application within 31 days after my other coverage ends. Additionally, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and dependents provided NCSD receives my completed enrollment application within 31 calendar days after the Qualifying Event.

If I decline enrollment for myself or dependents (including spouse/domestic partner) without other creditable coverage in force on this date, I understand I many not be eligible to enroll until the next Open Enrollment period.

My signature below is acknowledgement that all information on this form is true and complete. I am aware it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding any North Clackamas School District benefit plan. Penalties include imprisonment, fines, and denial of insurance.

_____ / / _____ / /

Employee Signature Date Benefits Specialist Authorization Date