Medical, Dental, Vision and Pre-Tax Premium Enrollment and Change Form

27J Schools
Office for Human Resources
Form No. SD27J 5/2021

Review all enrollment information, including information on page 2 of this form. Complete all required employee and dependent information.
Please use black ink only. Submit applicable additional documentation with this form.

A. Employee Information

School / Department:

Employee Last Name	Employee First Name	M.I.	Social Security Number	Employee Number

Home Address		County	Home Telephone No.
City	**State**	**Zip Code**	**Work Telephone No.**

Date of Birth (Month/Day/Year)	Gender (Circle one) Male / Female	Employment/Eligibility Date (Month/Day/Year)	Coverage Effective Date (Month/Day/Year)

B. Medical Plan Election — Kaiser Group No. 1112

- ☐ **Kaiser HDHP HSA Plan** 022-01 (Colorado)
- ☐ Kaiser DHMO Plan 023-01 (Colorado)

C. Medical Plan Enrollment Category

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee's Civil Union
- ☐ Employee & Child(ren)
- ☐ Employee, Spouse & Child(ren)

D. Dental Plan Election

- ☐ I elect to participate in the 27J Schools Group Dental Plan
- ☐ I decline to enroll in the 27J Schools Group Dental Plan

NOTE: Participation is required if you have enrolled in one of the Medical Plan options.

E. Dental Plan Enrollment Category

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee, Spouse & Child(ren)

The enrollment category must also be the same as the Medical Plan.

F. Vision Plan Election

☐ All eligible employees must enroll in the 27J Schools Vision Service Plan Group Plan No. 12 061882 0001

G. Vision Plan Enrollment Category

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee, Spouse & Child(ren)

H. Pre-tax Premium Election (This election shall be continuous unless revoked during the annual open enrollment period or due to a qualified change in status event)

☐ Yes, deduct premiums on a pre-tax basis ☐ No, deduct premiums on an after-tax basis ☐ Cancel pre-tax premium contributions

I. Medical / Dental / Vision Plan Participants

List all persons to be covered for medical, dental and vision coverage including yourself, spouse/domestic partner and each eligible unmarried dependent child

Name: First MI Last	Social Security Number	Relationship to Employee	Date of Birth Month/Day/Year	Gender: Male	Gender: Female	Coverage applies to: Medical	Coverage applies to: Dental	Coverage applies to: Vision
Employee:		SELF						
Spouse/Common Law/Domestic Partner/Civil Union		Circle One: Spouse, Com Law, Domestic Partner, Civil Union						
Dependent Child:								
Dependent Child:								
Dependent Child:								

J. Other Medical / Dental Plan Coverage

Are you or any of your covered dependents covered by another ***medical*** plan?	☐ Yes	☐ No	If yes, Insurance Carrier Name and Employer (if applicable)	Policy/Group Number:
Are you or any of your covered dependents covered by another ***dental*** plan?	☐ Yes	☐ No	If yes, Insurance Carrier Name and Employer (if applicable)	Policy/Group Number:

K. Coverage Changes (Complete for changes to existing medical / dental / vision coverage.)

Change Medical Plans:	Add Dependents — Effective date:		Remove Dependents — Effective date:			Cancel Employee Coverage
Reason	Person(s)	Reason	Person(s)	Reason		
☐ Open Enrollment ☐ Due to Job Transfer or Changing Your Residence	☐ Spouse ☐ Child(ren) List dependent's names above in Section I –Plan participants.	☐ Birth/Adoption ☐ Marriage ☐ Civil Union ☐ Spouse's employment change (attach document) ☐ Open Enrollment	☐ Spouse Name:_____ ☐ Child(ren) Name(s):_____	☐ Birth ☐ Death ☐ Marriage ☐ Civil Union ☐ Divorce ☐ Open Enrollment	☐ Child Ineligible ☐ Medicaid or Medicare ☐ Spouse's employment change (attach document)	☐ Medical ☐ Dental ☐ Vision Cancellation Effective date:_____

☐ Name Change (New name above.)
☐ Address Change (New address above)

Former Name / Former Address:

_____

_____

_____

L. Payroll & Legal Authorization (Must be signed and dated by employee or by a 27J Schools Benefits staff member for the default medical plan)

I hereby authorize my employer, until this authorization is revoked by written notice, to default my medical plan enrollment to the High Deductible Plan and deduct from each paycheck the amount applicable for the coverage options indicated. I hereby certify that the above information and any attachments thereto are true and correct. I understand that misrepresentation or falsification will subject me to penalties and possible legal action. I hereby certify that I have read and accept the terms and conditions described in the enrollment materials, including the reverse side of this form. I also agree to all of the terms as defined by the medical, dental, vision and pre-tax premium plans, if selected.

By signing this application/enrollment form I acknowledge that I am satisfied with my choice of plan(s), and that I have made the best choice for myself and my family. I further acknowledge that any advice, guidance, suggestions or information provided by 27J Schools, its employees or advisors, and by Kaiser Permanente, does not influence the fact that I am personally 100% liable for my choices. No retrospective changes to plan selection, enrollment, dependent information or other information on this form shall be allowed, unless those are due to administrative errors made by Kaiser Permanente or another carrier/TPA when capturing the information.

Employee Signature: _____ Date: _____

M. Enrollment Conditions (must be signed and dated):

1. I (we) authorize the release of all of my (our) medical records to the insurance company or its authorized agents for performance of any one or more of the following: (a) the administration of the Agreement; (b) medical research and education sanctioned by the insurance company; (c) peer review for quality assurance and utilization review by the insurance company or its authorized agents; (d) creation and provision of statistical utilization data to the subscribing group; (e) bona fide medical emergencies; and (f) any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.

2. I (we) will abide by the master contract applicable to the plan in which I (we) enrolled.

3. I (we) understand that by choosing the coverage specified in the Evidence of Coverage (EOC), paying the premium, or accepting benefits in the EOC, I (we) or my (our) legal representative expressly agree to all terms, conditions and provisions of the Evidence of Coverage.

4. 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 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. C.R.S. 10-1-127 (7)(a)

Employee Signature: _____ Date: _____

SPECIAL ENROLLMENT PERIOD

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your rights to Special Enrollment under this Plan when you or your eligible dependents decline coverage during the initial enrollment period.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within thirty-one (31) days after your other coverage ends. If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In order to qualify for the special enrollment period if you decline enrollment because of alternative group health coverage, 27J Schools Office for Human Resources must receive a **written statement** from you at the time of the initial enrollment period stating that other group coverage was the reason for declining enrollment.

Individuals who enroll under these special enrollment conditions are not considered late entrants.

In addition, if you have a **new** dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within **thirty-one (31) days** after the date of marriage, birth, adoption, or placement for adoption.

If you have any questions, please discuss them with staff in the Human Resources Benefits Office at the time of your enrollment.

NOTE: Medical plan ID cards will be mailed to new members by the insurance company. You will <u>not</u> receive an identification card for the dental or vision plans.