Santa Maria Independent School District

EMPLOYEE ACKNOWLEDGMENT OF RECEIPTOF BENEFIT INFORMATION AND INSURANCE ENROLLMENT INSTRUCTIONS

1. I hereby acknowledge that I received the Employee Benefits Package Outline. I understand that in order to elect any available insurance coverage(s), I must complete an Insurance Enrollment Form and return it to the Human Resources Department within 31 DAYS of becoming employed.
2.
3. I understand that if I fail to complete the form or if it is not received by the Human Resources Department before my effective date, I will not be able to enroll in any insurance until the next open enrollment period (August), or within 31 days of a qualifying event (birth or adoption of a child, marriage, divorce, death, change in status of spouse's employment).
4. If I elect Medical Health Insurance Coverage within the first 31 days of my employment, I understand that I have the option to select an effective date of date of hire or the first of the month following date of employment with Santa Maria ISD.
5. If I elect Dental, Vision, Disability, or any other insurance other than Medical Health Insurance, offered by Santa Maria ISD within the first 31 days of my employment, I understand that the effective date will be the first of the month following date of employment with Santa Maria ISD.
6. I understand that if the insurance premiums are not deducted from my paycheck on the first of the month following one full month of employment with Santa Maria ISD; I should assume my coverage(s) is/are not effective. I further understand that it is my responsibility to contact the Human Resources Department of Santa Maria ISD, Inc. within 15 days after my anticipated effective date to determine my insurance coverage status and to resolve any discrepancies regarding (1) insurance deductions or (2) incomplete or missing information, forms or proof of marital status. I hereby acknowledge that if I do not contact Human Resources to correct any discrepancies within 15 days of my effective date, I may have to wait until the next open enrollment to enroll in benefits.
7. I understand that by enrolling in any benefits plan, I will be responsible for all related premiums. I understand I may only cancel or change the policies during open enrollment (August), or as the result of a qualifying event.
8. I understand that if Santa Maria, Inc. or I terminate my employment, my medical and/or dental insurance will be cancelled effective the date of termination. I understand that any other policies in which I enroll will be cancelled effective at the end of the month of the termination and I will be responsible for premiums through the end of the month in which I terminate.
9. By my signature, I acknowledge that I give approval for payroll deductions of any applicable premiums associated with the insurance elections I make.
10. **I understand that signing this form will not enroll me in any benefit plans. Signing this form is simply an acknowledgement by me that I was informed and understand how to enroll.**

Name (Please Print)	Social Security Number
Signature	Date

Revised 10/30/09

It is the policy of Santa Maria ISD not to discriminate on the basis of race, color, national origin, sex or handicap in its vocational programs, services or activities as required by Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; and Section 504 of the Rehabilitation Act of 1973, as amended.