Easton Area School District
1801 Bushkill Drive • Easton, PA 18040-8186 • 610-250-2400

# *Application to Enroll or Change Enrollment for Health Benefits*

Plan Highlight sheets and how to access online accounts can be found at www.eastonsd.org
Visit Departments / Human Resources / Benefits.

## ***Capital Blue Cross & Delta Dental Bundle***

Capital Blue is the carrier for Medical and Rx. ID card will be mailed to your home address.

Delta Dental PPO is the carrier for Dental. Create an online account to view or print ID card.

Contribution amounts are provided in your Collective Bargaining Agreement (CBA).

Reference the CBA to confirm if there is a probation period before qualifying for enrollment into the plans. CBA's are on the website under Human Resources at www.eastonsd.org

## ***Vision Benefits of America (VBA)***

Vision Benefits of America (VBA) is the carrier for Vision. This plan is employee funded and optional coverage for employees who are actively employed.

Create an online account to view or print ID card at wwwvbaplans.com

Monthly fee for Single Coverage: $7.07

Monthly fee for 2 Party Coverage: $13.38

Monthly fee for Family Coverage: $18.34

New employees have thirty (30) days from their effective hire date to enroll.

Open enrollment is every June for an effective date of July 1st

Contact Human Resources at 610.250.2400 with questions regarding enrollment.

**Please Print and Return the Completed Application to Human Resources.**

## SECTION 1 – EMPLOYEE INFORMATION

Employee Name (Last, First, MI) | Social Security Number

Mailing Address

| Work Phone | Home Phone | Sex | Date of Birth | Date of Hire |
|---|---|---|---|---|
| ( ) | ( ) | ☐ Male ☐ Female ☐ Other | __/__/__ | __/__/__ |

## SECTION 2 – EMPLOYEE CLASSIFICATION

☐ Administration/Act 93
☐ Para Professional
☐ Teacher
☐ Custodian/Maintenance
☐ Administrative Professional
☐ Transportation

## SECTION 3 – REASON (S) FOR SUBMITTING ENROLLMENT FORM

☐ New Employee
☐ Open Enrollment Period
☐ Changes Outside Open Enrollment (Indicate Event Below)

**Qualifying Mid-Year Events (Indicate Event Below)**

**Date of Event:**_____

**Employment Change that Affects Eligibility**
☐ Employees begins leave without pay
☐ Employee returns from leave without pay
☐ Spouse or covered child gains employer eligibility
☐ Spouse or eligible child loses employer eligibility
☐ Spouse begins leave without pay
☐ Spouse ends leave without pay

**Legal Martial Status Change**
☐ Marriage *(copy of marriage certificate or license)*
☐ Divorce *(copy of front page of decree)*
☐ Death of Spouse *(copy of obituary or death certificate)*
☐

**Judgments Decrees or Orders**
☐ Judgment, decree or order allowing another party to cover your child(ren)
☐ Judgment, decree or order requiring coverage of a child(ren)

**Number of Eligible Family members Change**
☐ Adoption *(copy of adoption certificate)*
☐ Birth *(copy of birth certificate)*
☐ Covered child ceases to be eligible (exceeds plan's age limit, marries, becomes self-supporting, etc. *(certification of coverage)*
☐ Death of a covered child *(copy of obituary or death certificate)*
☐ Permanent custody granted (*copy of court order)*

**Medicare or Medicaid Change**
☐ Dependent gaining eligibility for Medicare or Medicaid
☐ Losing eligibility for Medicare or Medicaid

**Changes Due to Special Circumstances**
☐ HIPAA special enrollment due to loss of other group coverage
☐ Losing eligibility under another government-sponsored plan
☐ Employee or dependent moves in or out of a plan's service area

## SECTION 4 – ELECTION

**Type of Coverage**

☐ Employee Single ☐ Employee + 1 ☐ Family ☐ Waive Coverage

**Health Plan (Choose one)**
☐ Capital Blue PPO Medical / Rx with Delta Dental PPO

**Vision Plan (Choose if electing/changing)**
☐ Vision Benefits of America (VBA)

**Capital Blue and Delta Dental**

**Family member(s) to be covered or removed (list all including yourself)**

**Relationship Codes: Sp =Spouse S=Son D=Daughter SS=Stepson SD=Stepdaughter**

| Name (Include Last name if different) | Sex Code M/F | Date of Birth MM/DD/YYY | Social Security Number | Relationship Code | A – Add R- Remove |
|---|---|---|---|---|---|
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**Vision Benefits of America**

**Family member(s) to be covered or removed (list all including yourself)**

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## SECTION 6 – Medicare Coverage Information

| Complete if you or a dependent are currently enrolled in Medicare. | | Effective Date(s) | | Please check appropriate box. | |
|---|---|---|---|---|---|
| **Name of Subscriber or Dependent** | **Medicare Number** | **Medicare A** | **Medicare B** | **Disabled** | **ESRD?** |
| | | / / | / / | □Yes □ No | □Yes □ No |
| | | / / | / / | □Yes □ No | □Yes □ No |

## SECTION 7 – EMPLOYEE APPROVAL

I certify that I have reviewed the information of this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act (HIPAA).

I understand the benefit elections I have made on this form are in effect, as long as eligibility requirements are met, until I elect to change them, subject to the provisions of each plan. I have read the benefit materials and understand the limitations and qualifications of the benefit program. I authorize premium payments to be deducted from my pay under Section 125. (Deduction is made before taxes.)

Employee Signature _____ Date _____