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TRUMANSBURG SCHOOL DISTRICT

Health/Rx & Dental Benefits Enrollment/Change Form

Please Print– Please Complete ALL Applicable Sections

I am requesting Health and Dental Benefits	Family	Individual
I am requesting Health Benefits only	Family	Individual
I am requesting Dental Benefits only	Family	Individual

OFFICE USE

BCBS

LIFETIME

DEDUCTION BENEFITS ☐

Employee Information

Last Name: ______________________ First Name: ______________________ Middle Initial: ________

Social Security #: ___ ___ ____ Employee Date of Birth: ______/______/______

Mailing Address: ____

Street City State Zip

Day time phone #: ______________________ Email: (optional) ______________________

Please Check Desired Action:

Date of New Hire: ______________ (go to pg. 2) Date of Change to Eligible Status: ______________ (go to pg. 2)

Please Check All that Apply

I am requesting a change to my Health Care Plan elections due to a Qualifying Event*

Date of Qualifying Event: ______________________________ ☐ Health/Rx ☐ Dental

I would like to ADD a dependent(s) to my Health and/or Dental Plan due to a Qualifying Event*

Date of Qualifying Event: ______________________________ ☐ Health/Rx ☐ Dental

I would like to REMOVE a dependent(s) from my Health and/or Dental Plan due to a Qualifying Event*

Date of Qualifying Event: ______________________________ ☐ Health/Rx ☐ Dental

*Qualifying Events

Newly Hired/Newly Benefit Eligible Employees may skip this section.

Note: The section must be completed for any request to change Trumansburg, Health/Rx and/or Dental, outside of the annual open enrollment period due to a qualifying event. Requests must be received within 30 days of the qualifying event to be approved (changes for newly born and newly adopted children will be effective the date of birth or placement for adoption).

Please Select the Qualifying Event	
☐ Legal Marriage	☐ Loss of Coverage
☐ Legal Divorce	☐ Court Order to cover an Eligible Dependent
☐ Birth of a Child/Adoption of a Child	☐ Retiree Open Enrollment
☐ Dependent Loses Eligibility	☐ Spouse/Dependent Passes Away
☐ Gain Eligibility for Medicaid/Medicare	☐ Loss Eligibility for Medicaid/Medicare
☐ Approved Leave: (i.e. Military Leave, Layoff)	☐ Return from Leave (i.e. Military Leave, Layoff)
☐ Employee Open Enrollment,	☐ Dependent Gains Eligibility Through Their Own

TRUMANSBURG SCHOOL DISTRICT

Health/Rx & Dental Benefits Enrollment/Change Form

Other Coverage Information

EMPLOYEE INFORMATION:

Are you covered under any other health insurance contract now or within the last 63 days, including Medicaid or Medicare?

Yes or No - If yes, please provide: A copy of you or your spouse's identification card and fill out the information below

Member Name: ______________________ Member Address: ______________________

Effective date of coverage: ______________ End date of coverage: __________

Carrier Name/Address: ______________________ Member ID#: __________ Policy #: __________

Medicare Number (if applicable):__________ Part A Effective Date:________ Part B Effective Date:__________.

Marital Status (circle one): Single / Married / Separated / Divorced / Widowed

If Married, Date of Marriage: ______________

Last Name: ______________ First Name: ______________ Middle Initial: ______

Address: (If Different from Employee):____

Street City State Zip

Is your Spouse Employed? Yes or No - If yes, please provide the following:

Employer Name: ____

Employer Address: ____

Street City State Zip

Is your Spouse covered under any other health insurance contract now or within the last 63 days, including Medicaid or Medicare?

Yes or No - If yes, please provide:

Effective date of coverage: ______________ End date of coverage: __________

Carrier Name/Address: ______________________ Member ID#: __________ Policy #: __________

Medicare Number (if applicable):__________ Part A Effective Date:________ Part B Effective Date:__________.

Are you required by court order to provide health insurance benefits to your spouse? Yes or No

If yes, please provide a copy of the court order along with this form.

PRESENTATION OF A FALSE STATEMENT IN SUPPORT OF AN APPLICATION FOR HEALTH INSURANCE COVERAGE OR A CLAIM FOR PAYMENT IS PROHIBITED BY SECTION 176.05 OF THE PENAL LAW

______________________________ ________ / ________ / __________

Signature Month Day Year

TRUMANSBURG SCHOOL DISTRICT

Health/Rx & Dental Benefits Enrollment/Change Form

Please Print– Complete ALL Applicable Sections

Spouse's Information	Social Security # (Required)	Gender M/F	Date of Birth (MM/DD/YYYY)	Would you like coverage on Trumansburg's Excellus BCBS Health/Rx Plan	Would you like coverage on Trumansburg's Lifetime Benefits Dental Plan
Name ______________________	SS # ____/____/______	☐ M ☐ F	____/____/______	☐ YES ☐ NO	☐ YES ☐ NO
Dependent Children's Information (If your dependent child is Handicapped please check the appropriate box in addition)	Social Security # (Required)	Gender M/F	Date of Birth (MM/DD/YYYY)	Would you like coverage on Trumansburg's Excellus BCBS Health/Rx Plan	Would you like coverage on Trumansburg's Lifetime Benefits Dental Plan
Name ______________________ ☐ Child to age 26 ☐ Handicapped	SS # ____/____/______	☐ M ☐ F	____/____/______	☐ YES ☐ NO	☐ YES ☐ NO
Name ______________________ ☐ Child to age 26 ☐ Handicapped	SS # ____/____/______	☐ M ☐ F	____/____/______	☐ YES ☐ NO	☐ YES ☐ NO
Name ______________________ ☐ Child to age 26 ☐ Handicapped	SS # ____/____/______	☐ M ☐ F	____/____/______	☐ YES ☐ NO	☐ YES ☐ NO
Name ______________________ ☐ Child to age 26 ☐ Handicapped	SS # ____/____/______	☐ M ☐ F	____/____/______	☐ YES ☐ NO	☐ YES ☐ NO

Excellus BCBS Health/Rx – Available to Dependents: until the age of 26; or age 29 if qualified for Young Adult (see Page 6 of this packet)

Lifetime Benefit Solutions (LBS) Dental – Available to Dependents: until the age of 19; or age 25 if FT Student (see Page 6 of this packet)

** Eligibility Verification Requirements for each Dependent must be attached **

Complete for each dependent and return it with the required documentation to confirm eligibility of your Dependent(s).

Required eligibility verification can be found starting on Page 5 of this packet.

DEPENDENT CHILDREN INFORMATION

Dependent Last Name: ____________________Dependent First Name: ___________________ Middle Initial: ______Relationship to Employee: ____________________

Dependent Address (if Different from Employee): ________________________________Is the dependent married? Yes or No If yes, marriage date: _____________

Is the dependent employed? Yes or No Employer Name: ____________________________________Employer Address: ____

Is the dependent eligible for health insurance from their employer listed above? Yes or No

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? Yes or No

If yes, please provide: Effective date of coverage: _____________________ Member ID#: ________________________Carrier Name/Address: ______________________

Are you required by court order to provide health insurance benefits to this dependent? Yes or No If yes, please provide a copy of the court order along with this form.

Is dependent considered handicapped (totally disabled)? Yes or No Date of dependent's disability _________________

Does this dependent have personal income from any source? Yes or No Is this dependent claimed on employee's income tax? Yes or No

Dependent Last Name: ____________________Dependent First Name: ___________________ Middle Initial: ______Relationship to Employee: ____________________

Dependent Address (if Different from Employee): ________________________________Is the dependent married? Yes or No If yes, marriage date: _____________

Is the dependent employed? Yes or No Employer Name: ____________________________________Employer Address: ____

Is the dependent eligible for health insurance from their employer listed above? Yes or No

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? Yes or No

If yes, please provide: Effective date of coverage: _____________________ Member ID#: ________________________Carrier Name/Address: ______________________

Are you required by court order to provide health insurance benefits to this dependent? Yes or No If yes, please provide a copy of the court order along with this form.

Is dependent considered handicapped (totally disabled)? Yes or No Date of dependent's disability _________________

Does this dependent have personal income from any source? Yes or No Is this dependent claimed on employee's income tax? Yes or No

Dependent Last Name: ____________________Dependent First Name: ___________________ Middle Initial: ______Relationship to Employee: ____________________

Dependent Address (if Different from Employee): ________________________________Is the dependent married? Yes or No If yes, marriage date: _____________

Is the dependent employed? Yes or No Employer Name: ____________________________________Employer Address: ____

Is the dependent eligible for health insurance from their employer listed above? Yes or No

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? Yes or No

If yes, please provide: Effective date of coverage: _____________________ Member ID#: ________________________Carrier Name/Address: ______________________

Are you required by court order to provide health insurance benefits to this dependent? Yes or No If yes, please provide a copy of the court order along with this form.

Is dependent considered handicapped (totally disabled)? Yes or No Date of dependent's disability _________________

TRUMANSBURG SCHOOL DISTRICT

Health/Rx & Dental Benefits Enrollment/Change Form

BENEFIT ELIGIBILITY VERIFICATION - REQUIRED

CHILD – NATURAL, ADOPTED, STEPCHILD – REQUIRED DOCUMENTATION

PROOF OF RELATIONSHIP – REQUIRED FOR ALL CHILDREN TO BE CONSIDERED FOR BENEFITS

- BIOLOGICAL CHILDREN < AGE 26 (for Health/Rx) & BIOLOGICAL CHILDREN < AGE 19 OR FT STUDENT < AGE 25 (for Dental)
  - Copy of government issued Birth Certificate, containing the child's name, birth date and parents' names.
  - A non government issued Birth Certificate including the child's name, date of birth, and parents' names may be used if the child is less than 3 months in age.
- ADOPTED CHILDREN < AGE 26 (for Health/Rx) & ADOPTED CHILDREN < AGE 19 OR FT STUDENT < AGE 25 (for Dental)
  - Adoption Placement Agreement including the child's date of birth or Petition of Adoption including the child's date of birth.
  - Adoption Certificate, adoption papers, or other official document issued by the U.S. Government, including the child's date of birth.
- ADULT CHILD >26 AND <30 YOUNG ADULT OPTION (NEW YORK STATE MANDATE 7/1/2010) (For Health/Rx Only)
  - Proof of dependent residency required – one of the following in the dependent's name

    Driver's license,
    - Auto registration
    - Tax return
    - Passport
    - Utility/telephone bill
    - Lease agreement
- HANDICAPPED CHILD
  - Your most recent filed Tax Return listing child as dependent
  - Copy of dependent's last psychological evaluation, WAIS and/or MMPI Report.
  - Form completed and signed by child's attending physician

INSURANCE ENROLLMENT OPTIONS

PRE-TAX – POST TAX –ELECTION/DECLINATION FORM

(Please Print) Last Name:____________________First Name: ___________________________Effective Date:____________.

TRUMANSBURG SCHOOL DISTRICT

PREMIUM PRE TAX ELECTION OPTION

I would like the following benefits premiums to be taken out of my paycheck on a pre-tax basis. I understand that I may not change this election during the 12 months from September to August unless I meet the IRS regulations as having a life change.

_____Health/Rx Insurance _____Family _____Individual

_____Dental Insurance _____Family _____Individual

I also understand that I can change this option annually during open enrollment period.

Signature: ___________________________ Date: ____________________

TRUMANSBURG SCHOOL DISTRICT

PREMIUM POST-TAX ELECTION OPTION

I would like the following benefits premiums to be taken out of my paycheck on a post-tax basis. I understand that I may not change this election during the 12 months from September to August unless I meet the IRS regulations as having a life change.

_____Health/Rx Insurance _____Family _____Individual

_____Dental Insurance _____Family _____Individual

I also understand that I can change this option annually during open enrollment period.

Signature: _________________________ Date: __________________