Kenai Peninsula Borough School District Health Care Plan
Participant Enrollment Form

REHN & ASSOCIATES

EMPLOYEE ENROLLMENT INFORMATION

NAME:			Date of Enrollment or Change:
Social Security Number:		Sex: ❑ M ❑ F	IHS (Indian Health Services)Eligible: ❑ Y ❑ N
Mailing Address:			Date of Birth:
City:	State:	Zip:	Marital Status:
Phone:	Email:		Date of Marriage:

TYPE OF ENROLLMENT/LEGAL DOCUMENTATION

Legal documentation is required for all new enrollments and any changes made:

❑ New Enrollment ❑ Open Enrollment ❑ Change in Status

❑ DECLINING COVERAGE Note: You may decline only if you have other health coverage outside KPBSD that meets the minimum Affordable Care Act requirements.

Reason for electing, changing or declining coverage: _____

❑ I wish to DECLINE Dental/Vision coverage (I understand this will NOT reduce/change my contribution amount)

COVERAGE AND DEPENDENT INFORMATION

One plan option must be selected: *Copies of marriage certificate and children's birth certificates required*

❑ HRA Plan (Health Reimbursement Arrangement) *You may choose to opt-out of HRA reimbursements by contacting the Benefits Manager*

❑ HSA Plan (Health Savings Account) *IMPORTANT: HSA Enrollment Form required* *Please see the HSA FAQ for IRS eligibility guidelines*

Add	Drop	Relationship to Employee	Last Name	First Name	Middle Initial	IHS Eligible	Social Security No.	Date of Birth	Employer	Gender
❑	❑	SPOUSE				❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F

Is any child over the dependent age limit applying for coverage due to disability? ❑No ❑Yes→*Complete the Request for Certification of Disabled Dependent form.*

Does any dependent have a different mailing address? ❑ No ❑ Yes→ _____

List Dependent name

_____

Write in Dependent mailing address including City, State and ZIP Code

OTHER COVERAGE INFORMATION

Do you, your spouse and/or your covered dependents have other coverage for: If yes, please attach a Certificate of Creditable Coverage from your current carrier(s) – Certificates only apply to newly enrolled Employees & Dependents.

Medical ❑ No ❑ Yes Dental ❑ No ❑ Yes Vision ❑ No ❑ Yes Prescriptions ❑ No ❑ Yes Medicare ❑ No ❑ Yes

COVERAGE #1:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name_____

ID #:_____ Effective Date: _____ Individuals currently covered under this policy: _____

COVERAGE #2:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name: _____

ID #:_____ Effective Date: _____ Individuals currently covered under this policy: _____

SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF MEDICAL INFORMATION OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND FOR MY DEPENDENTS, AND THAT I WILL BE GUILTY OF INSURANCE FRAUD. I authorize deductions, if any, from any earnings toward the cost of the coverage. A copy of this authorization shall be as valid as the original.

Sign Here →

_____	_____	_____
Employee's Signature	*Print Name*	*Date*

THIS SECTION TO BE COMPLETED BY EMPLOYER

Exact date of full-time employment:	Effective Date:	Date Processed:	
Month Day Year	Month Day Year	Month Day Year	Plan Administrator