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: _____

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 Packet required***

Choose Tier: ❑ **Employee** ❑ **Employee/Spouse** ❑ **Employee/Child(ren)** ❑ **Family**

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
❑	❑					❑Y ❑N				❑ M❑F

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 **Medicaid** ❑ 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

Kenai Peninsula Borough School District Health Care Plan

Spousal Surcharge Affidavit

1. EMPLOYEE INFORMATION			
EMPLOYEE NAME:			**Employee#**
Social Security Number:			**Date of Birth:**
Mailing Address:			**Sex:** ❑ M ❑ F
City:	**State:**	**Zip:**	

2. SPOUSE INFORMATION

This section must be completed if you are enrolling your spouse. If you are married but not enrolling your spouse, this form is not required.

1. **Spouse's name:** _____
2. **Is your spouse employed?**
   - ❑ **YES**
   - ❑ **NO** (If no, please skip to section 3)
3. ***Is your spouse eligible for health benefits through their employer?**
   - ❑ **YES**
   - ❑ **NO** (If no, please skip to section 3)
4. **Is your spouse enrolled in health benefits through their employer?**
   - ❑ **YES**
   - ❑ **NO**
5. **If you responded YES to number 4, is your spouse's coverage a reduced benefit plan that shifts the majority of the cost of medical claims to the Secondary Plan?**
   - ❑ **YES**
   - ❑ **NO**

You are subject to a $200 per month surcharge ($240 prorated for 9-month employees through 6/30/2026) if your spouse declines health coverage available through their employer, or if your spouse enrolls in a reduced benefit plan which shifts primary coverage to the Kenai Peninsula Borough School District Health Plan.

❑ **YES,** I understand that I am subject to a $200 monthly surcharge for enrolling my spouse under the Kenai Peninsula Borough School District Health Plan when they are eligible, but not enrolled for coverage through their employer or my spouse is enrolled with their employer, but the Kenai Peninsula Borough School District Health Plan will be their Primary plan.

**Your spouse is considered eligible if their job position entitles them to health benefits through their employer, even if they declined coverage or failed to enroll timely and therefore are without health coverage through their employer.*

I understand that if my spouse's group health insurance status changes, it is my responsibility to notify Employee Benefits Manager in writing within 31 days of such change. Any false statements written on this form or on future forms as it relates to spousal health information shall be considered grounds for disciplinary action.

3. 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 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