



Kenai Peninsula Borough School District Health Care Plan Participant Enrollment Form



EMPLOYEE ENROLLMENT INFORMATION

NAME:			Date of Enrollment or Change:		
Social Security Number:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	IHS (Indian Health Services) Eligible: <input type="checkbox"/> Y <input type="checkbox"/> 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 Form 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
<input type="checkbox"/>	<input type="checkbox"/>	SPOUSE				<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> 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