TAFTCOLLEGE

2018-19 Open Enrollment

August 10 – 31, 2018

Enrollment forms are due to Human Resources no later than August 31, 2018. Elections made during open enrollment are effective October 1, 2018. For detailed plan information please contact a member of Human Resources or visit http://www.taftcollege.edu/human-resources/human-resources/openenrollment.

Personal Information: *Please Print or Type*

Employee Name:	Employee Number: A
Street Address:	City, State, Zip:
Date of Birth:	Phone Number:

Medical: *Provider: Anthem Blue Cross. If an enrollment form is not received, you will default to medical plan 100-D. For detailed plan information please refer to the plan comparison available on the website. Please select only one option.*

Plan Name	Deductible	Co-pay	RX	Employee Monthly Premium	Election
100-D PPO	$300/$600	$20	$9-$35	$0.00	
100-G PPO	$500/$1000	$20	$5-$20	$0.00	
100-A PPO	$0/$0	$20	$5-$20	$116.00	

Dental: *Provider: Delta Dental. Please select only one option.*

Plan Name	Annual Plan Maximum	Orthodontia Coverage	Employee Monthly Premium	Election
Traditional Incentive	$1,700	None	$0.00	
Preferred Option DPO	$3,000	100% up to $3,000	$0.00	

Vision: *Provider: VSP. Coverage is included with all listed medical plans*

Dependent Changes: *If you need to add or remove a dependent, please complete the below. Attach additional sheets as needed*

Add/Remove	Name	Date of Birth	SSN	Relationship	Plans
☐ Add ☐ Remove				☐ Spouse ☐ Domestic Partner ☐ Child	☐ Medical ☐ Dental ☐ Vision
☐ Add ☐ Remove				☐ Spouse ☐ Domestic Partner ☐ Child	☐ Medical ☐ Dental ☐ Vision

Acknowledgements:

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility, I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- **DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required contribution.
- **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- **I understand that my elections are binding for the plan year and that changes can only be made due to a change in family status.** I understand it is my responsibility to notify the District within 30 days of any eligible change in family status.

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

Name: ______________________________ Date: ______________________

Signature: ____