

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
<input type="checkbox"/> Add <input type="checkbox"/> Remove				<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Remove				<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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: _____

