TAFTCOLLEGE

2020-21 Open Enrollment

July 29 – August 25, 2020

Open enrollment is passive for this plan year. Enrollment forms only need to be completed if you are making changes to your current elections. Enrollment forms are due to Human Resources no later than August 25, 2020. Elections made during open enrollment are effective October 1, 2020. 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	$123.00	☐

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

Plan Name	Annual Plan Maximum	Orthodontia Coverage	Employee Monthly Premium	Election
Dental Essential Choice	$4,000	100% up to $2,000	$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: _____