

Employee Name:

Street Address:

Signature: _

Personal Information: *Please Print or Type*

2020-21 Open Enrollment

July 27 - August 25, 2020

Open enrollment is passive for this plan year. Enrollment forms <u>only</u> need to be completed <u>if</u> you are making changes to your current elections. Enrollment forms are due to Human Resources <u>no later</u> 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.

Employee Number: A

City, State, Zip:

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. 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 Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded.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 cop 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 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.	Date of Birth:							Phone Number:					
Plan Name Deductible Co-pay RX Employee Monthly Premium Election				_		-		-		-). Fo	r detailed
100-D PPO	-												
100-G PPO \$500/\$1000 \$20 \$5-\$20 \$123.00								• • •			Election		
Dental: Provider: Delta Dental. Please select only one option. Plan Name								'					
Dental: Provider: Delta Dental. Please select only one option. Plan Name Annual Plan Coverage Premium 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 Spouse Medical Domestic Partner Dental Spouse Medical Plans Add Spouse Medical Domestic Partner Dental Spouse Medical Plans 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: 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 are your 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. Aver ead 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 cop 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				<u> </u>				-					
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Preferred Option DPO \$3,000 100% up to \$2,000 \$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 Spouse Medical Domestic Partner Dental Child Vision Add Spouse Medical Child Vision Add Spouse Medical Domestic Partner Dental Child 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. 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 cop of this signed authorization for your flies. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filling a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below tha lawe reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accur	Plan Nar	Ar	Annual Plan			rthodo	ontia Em		loyee Monthly	Election			
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