NEWFIELD CENTRAL SCHOOL HEALTH INSURANCE

Health/Rx & Dental/Vision Benefits Enrollment/Change Form

Please Print– Please Complete ALL Applicable Sections

Employee Benefit Office Use Only
H/Rx: ☐ WC ☐ E Dental: ☐ WC ☐ A Vision: ☐ WC ☐ D
☐ Fam ☐ Indv ☐ Fam ☐ Indv ☒ Fam ☐ Indv
Plan: ☐ YM ☐ BSI Group _____ Sub-Group _____

Employee Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security #:_____-_____-_____ Employee Date of Birth: _____/_____/_____

Mailing Address: _____
Street City State Zip

Home Address: _____
(If different) Street City State Zip

Day time phone #: _____Email: (optional)_____

Please Check Desired Action:

☐ I am newly hired ***(go to page 2)*** **or;** ☐ I am newly, benefit eligible employee enrolling in benefits ***(go to page 2)***

Date of Hire:_____ **Date of Change to Eligible Status:**_____

☐ Other/Explain: _____**Effective Date:**_____

(if not a qualifying event listed below, there is a three-month waiting period from the date of the receipt of this form for health insurance. For dental and vision, changes not due to a qualifying event must be made during the next Open Enrollment period.)

Please Check All that Apply

☐ I am requesting a change to my Health Care Plan elections due to a Qualifying Event*
Date of Qualifying Event:_____ ☐ Health/Rx ☐ Dental ☐ Vision

☐ I would like to ADD a dependent(s) to my Health, Vision and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:_____ ☐ Health/Rx ☐ Dental ☐ Vision

☐ I would like to REMOVE a dependent(s) from my Health, Vision and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:_____ ☐ Health/Rx ☐ Dental ☐ Vision

***Qualifying Events**

Newly Hired/Newly Benefit Eligible Employees may skip this section.

Note: The section must be completed for any request to change Health/Rx and/or Dental or Vision, outside of the annual open enrollment period due to a qualifying event. **Requests must be received within 30 days of the qualifying event to be approved (changes for newly born and newly adopted children will be effective the date of birth or placement for adoption**).

Please Select the Qualifying Event	
☐ Legal Marriage	☐ Involuntary Loss of Coverage
☐ Legal Divorce	☐ Court Order to cover an Eligible Dependent
☐ Birth of a Child/Adoption of a Child	☐ Retiree
☐ Dependent Loses Eligibility	☐ Spouse/Dependent Passes Away
☐ Gain Eligibility for Medicaid/Medicare	☐ Loss Eligibility for Medicaid/Medicare
☐ Approved Leave: (i.e. Military Leave, Layoff)	☐ Return from Leave (i.e. Military Leave, Layoff)
	☐ Dependent Gains Eligibility Through Their Own

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EMPLOYEE INFORMATION:

Enrolling in: ☐ Health/Rx ☐ Dental (High _____ OR Low _____) ☐ Vision

Previous Coverage: Are you covered under any other health insurance contract now or within the last 60 days, **including Medicaid or Medicare**?

Yes or No - If yes, please provide:

Effective date of coverage: _____ End date of coverage: _____

Carrier Name/Address: _____Member ID#:_____ Policy #: _____

Policy Holder's Name:_____ Type of Coverage: ☐ Health ☐ Dental ☐ Health & Dental

Medicare Number (if applicable):_____ Part A Effective Date:_____ Part B Effective Date:_____.

Marital Status (circle one): Single / Married / Separated / Divorced / Widowed-If Married, Date of Marriage: _____

SPOUSE (INCLUDING SAME SEX SPOUSES, IF LEGALLY MARRIED):

Last Name: _____ First Name: _____ Middle Initial: _____

Address: (If Different from Employee):_____

Street City State Zip

Is your Spouse Employed? ***Yes or No - If yes***, please provide the following:

Employer Name: _____

Employer Address: _____

Street City State Zip

Is your Spouse covered under any other health insurance contract now or within the last 60 days, **including Medicaid or Medicare**?

Yes or No - If yes, please provide:

Effective date of coverage: _____ End date of coverage: _____

Carrier Name/Address: _____Member ID#:_____ Policy #:_____

Policy Holder's Name:_____ Type of Coverage: ☐ Health ☐ Dental ☐ Health & Dental

Medicare Number (if applicable):_____ Part A Effective Date:_____ Part B Effective Date:_____.

Are you required by court order to provide health insurance benefits to your spouse? ***Yes or No***

If yes, please provide a copy of the court order along with this form.

PRESENTATION OF A FALSE STATEMENT IN SUPPORT OF AN APPLICATION FOR HEALTH INSURANCE COVERAGE OR A CLAIM FOR PAYMENT IS PROHIBITED BY SECTION 176.05 OF THE PENAL LAW

_____ _____ / _____ / _____

Signature ***Month*** ***Day*** ***Year***

NEWFIELD CENTRAL SCHOOL HEALTH INSURANCE

Health/Rx & Dental/Vision Benefits Enrollment/Change Form

Before completing enrollment in the NEWFIELD Central School Plan(s), you should read the Benefit Plan. This information explains enrollment and eligibility requirements, plan descriptions, and insurance company contact information. (Required eligibility verification can be found starting on Page 5 of this Form.)

Please Print– Complete ALL Applicable Sections

Spouse's Information	Social Security # (Required)	Gender M/F	Date of Birth (MM/DD/YYYY)	Would you like to cover on your NEWFIELD School Excellus BCBS **Health/Rx Plan**	Would you like to cover on your NEWFIELD School Ameritas **Dental Plan**	Would you like to cover on your NEWFIELD School Davis **Vision Plan**
Name:	SS # ____/____/	☐ M ☐ F	____/____/	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Dependent Children's Information (If your dependent child is Handicapped please check the appropriate box in addition)	Social Security # (Required)	Gender M/F	Date of Birth (MM/DD/YYYY)	Would you like to cover on your NEWFIELD School Excellus BCBS **Health/Rx Plan**	Would you like to cover on your NEWFIELD School Ameritas **Dental Plan**	Would you like to cover on your NEWFIELD School Davis **Vision Plan**
Name: ☐ Child to age 26 ☐ Handicapped	SS # ____/____/	☐ M ☐ F	____/____/	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Name: ☐ Child to age 26 ☐ Handicapped	SS # ____/____/	☐ M ☐ F	____/____/	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Name: ☐ Child to age 26 ☐ Handicapped	SS # ____/____/	☐ M ☐ F	____/____/	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Name: ☐ Child to age 26 ☐ Handicapped	SS # ____/____/	☐ M ☐ F	____/____/	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Excellus BCBS Health/Rx and Vision– Available to Dependents until the age of 26; or age 29 if qualified for Young Adult (see Pg 6)

Dental – Available to Dependents: until the age of 20; or age 26 if FT Student (see Pg 6)

**** Eligibility Verification Requirements for each Dependent must be attached ****

Complete for each dependent and return it with the required documentation to confirm eligibility of your Dependent(s).

DEPENDENT CHILDREN INFORMATION:

Dependent Last Name: _____Dependent First Name: _____ Middle Initial: _____Relationship to Employee: _____

Dependent Address (if Different from Employee): _____Is the dependent married? ***Yes or No*** If yes, marriage date: _____

Is the dependent employed? ***Yes or No*** Employer Name: _____Employer Address: _____

Is the dependent eligible for health insurance from their employer listed above? ***Yes or No***

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? ***Yes or No***

If yes, please provide: Effective date of coverage: _____ Member ID#: _____Carrier Name/Address: _____

Are you required by court order to provide health insurance benefits to this dependent? ***Yes or No*** If yes, please provide a copy of the court order and QMSCO along with this form.

Is dependent considered handicapped (totally disabled)? ***Yes or No*** Date of dependent's disability _____

Does this dependent have personal income from any source? ***Yes or No*** Is this dependent claimed on employee's income tax? ***Yes or No***

Is this dependent a full time student? ***Yes or No*** If yes, please provide proof of enrollment.

Dependent Last Name: _____Dependent First Name: _____ Middle Initial: _____Relationship to Employee: _____

Dependent Address (if Different from Employee): _____Is the dependent married? ***Yes or No*** If yes, marriage date: _____

Is the dependent employed? ***Yes or No*** Employer Name: _____Employer Address: _____

Is the dependent eligible for health insurance from their employer listed above? ***Yes or No***

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? ***Yes or No***

If yes, please provide: Effective date of coverage: _____ Member ID#: _____Carrier Name/Address: _____

Are you required by court order to provide health insurance benefits to this dependent? ***Yes or No*** If yes, please provide a copy of the court order and QMSCO along with this form.

Is dependent considered handicapped (totally disabled)? ***Yes or No*** Date of dependent's disability _____

Does this dependent have personal income from any source? ***Yes or No*** Is this dependent claimed on employee's income tax? ***Yes or No***

Is this dependent a full time student? ***Yes or No*** If yes, please provide proof of enrollment.

Dependent Last Name: _____Dependent First Name: _____ Middle Initial: _____Relationship to Employee: _____

Dependent Address (if Different from Employee): _____Is the dependent married? ***Yes or No*** If yes, marriage date: _____

Is the dependent employed? ***Yes or No*** Employer Name: _____Employer Address: _____

Is the dependent eligible for health insurance from their employer listed above? ***Yes or No***

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? ***Yes or No***

If yes, please provide: Effective date of coverage: _____ Member ID#: _____Carrier Name/Address: _____

Are you required by court order to provide health insurance benefits to this dependent? ***Yes or No*** If yes, please provide a copy of the court order and QMSCO along with this form.

Is dependent considered handicapped (totally disabled)? ***Yes or No*** Date of dependent's disability _____

Does this dependent have personal income from any source? ***Yes or No*** Is this dependent claimed on employee's income tax? ***Yes or No***

Is this dependent a full time student? ***Yes or No*** If yes, please provide proof of enrollment.

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The following lists the required documentation to be provided along with the above form for each family member to be considered for benefit eligibility.

SPOUSE (OPPOSITE SEX AND SAME SEX) – REQUIRED DOCUMENTATION

Government Issued Marriage Certificate (if Married in the Last 12 Months)

OR

*Government Issued Marriage Certificate **AND** Most recent Federal or State Tax Return*

- Your most recent filed Tax Return showing "married filing jointly" OR "married filing separately". Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status (or vice versa).

- Only submit page 1 of the return. This could include the 1040 form, e-File Confirmation Page, Tax Preparer's Summary, Federal Return Recap, or Tele-File.

- Mark out all financial information and the first five digits of all Social Security numbers.

OR

*Government Issued Marriage certificate **AND** Proof of Joint Ownership or Residency*

- Submit **BOTH** your marriage certificate and proof of joint ownership or residency. Both the enrollee's and spouse's name must be listed on the documentation of joint ownership or residency and contain recent dates (within the last 6 months). Examples include copy of:
    - Mortgage Statement
    - Homeowners/Renters Insurance Policy
    - Property Tax Document
    - Rental/Lease Agreement
    - Credit Card Statement
    - Loan Obligation
    - Bank Account Statement -

NEWFIELD CENTRAL SCHOOL HEALTH INSURANCE

Health/Rx, Vision & Dental Benefits Enrollment/Change Form

BENEFIT ELIGIBILITY VERIFICATION - REQUIRED

CHILD – NATURAL, ADOPTED, STEPCHILD – REQUIRED DOCUMENTATION

PROOF OF RELATIONSHIP – REQUIRED FOR ALL CHILDREN TO BE CONSIDERED FOR BENEFITS

- **BIOLOGICAL CHILDREN < AGE 26 (for Health/Rx or Vision) & BIOLOGICAL CHILDREN < AGE 20 OR FT STUDENT < AGE 26 (for Dental)**
    - Copy of government issued Birth Certificate, containing the child's name, birth date and parents' names.
    - A non-government issued Birth Certificate including the child's name, date of birth, and parents' names may be used if the child is less than 3 months in age.
- **ADOPTED CHILDREN < AGE 26 (for Health/Rx or Vision) & ADOPTED CHILDREN < AGE 20 OR FT STUDENT < AGE 26 (for Dental)**
    - Adoption Placement Agreement including the child's date of birth or Petition of Adoption including the child's date of birth.
    - Adoption Certificate, adoption papers, or other official document issued by the U.S. Government, including the child's date of birth.
- **ADULT CHILD >26 AND <30 YOUNG ADULT OPTION (NEW YORK STATE MANDATE-7/1/2010) (For Health/Rx Only)**
    - **Proof of dependent residency required – one of the following in the dependent's name**

      Driver's license,

      - Auto registration
      - Tax return
      - Passport
      - Utility/telephone bill
      - Lease agreement
- **HANDICAPPED CHILD**
    - Your most recent filed Tax Return listing child as dependent
    - Copy of dependent's last psychological evaluation, WAIS and/or MMPI Report.
    - Form completed and signed by child's attending physician

INSURANCE ENROLLMENT OPTIONS

PRE-TAX – POST TAX –ELECTION/DECLINATION FORM

(Please Print) **Last Name:**_____**First Name:** _____**Effective Date:**_____.

PREMIUM PRE TAX ELECTION OPTION

I would like the following benefits premiums to be taken out of my paycheck on a **pre-tax basis**. I understand that I may not change this election during the 12 months from September to August unless I meet the IRS regulations as having a life change.

_____Health/Rx Insurance _____Family _____Individual

_____Vision Insurance _____Family _____Individual

_____Dental Insurance _____Family _____Individual

I also understand that I can change this option annually.

Signature: _____ Date: _____

PREMIUM POST-TAX ELECTION OPTION

I would like the following benefits premiums to be taken out of my paycheck on a **post-tax basis**. I understand that I may not change this election during the 12 months from September to August unless I meet the IRS regulations as having a life change.

_____Health/Rx Insurance _____Family _____Individual

_____Vision Insurance _____Family _____Individual

_____Dental Insurance _____Family _____Individual

I also understand that I can change this option annually.

Signature: _____ Date: _____

INSURANCE ENROLLMENT OPTIONS

EMPLOYEE WAIVER FORM

I understand that by waiving coverage I will not be eligible to enroll without a three-month waiting period (health insurance) or until the groups' next open enrollment for vision and/or dental.

☐ I waive my employer's group health insurance coverage for myself and my dependents (if any).
☐ I waive my employer's group vision insurance coverage for myself and my dependents (if any).
☐ I waive my employer's group dental insurance coverage for myself and my dependents (if any).

Please check the appropriate box below and provide all applicable information:

Reason for Waiving coverage:

☐ Covered through spouse's employer ☐ Covered through a parent's employer

☐ Under 65 Retiree covered by previous employer's insurance program

☐ Other - Explain:_____.

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example: within 30 days of involuntarily loss of other group coverage; with a three-month waiting period (for health insurance) or at the time of Open Enrollment (vision and/or dental)

The information provided above is true and accurate to the best of my knowledge. I acknowledge that I have been apprised of my right to receive insurance coverage in compliance with the provisions of the Patient Protection and Affordable Care Act. I knowingly and voluntarily agree to waive my right to receive insurance from NEWFIELD Central School.

_____ _____ / _____ / _____

Signature ***Month*** ***Day*** ***Year***