District 49 - 2024

Medical, Dental, and Vision Enrollment/Change Form

Full Employee Name:		SSN(last 4):	Date of Birth:	
Address:		City:	State:	Zip:
Home / Cell Phone:	Work Phone:	Email address:		
Date of Hire: (New Hires Only)	**Emp'e ID#:**			

Effective Date:	□ Birth/Adoption □ Marriage □ Divorce □ Loss of Coverage □ Other Insurance □ Other _____	Type of Change: □ Cancel Coverage □ Add Coverage □ Cancel Dependents □ Add Dependents

*All changes must be made within 31 days of the qualifying event. These changes are as follows: marriage, divorce, birth, adoption, loss of other health coverage, divorce or legal separation, death, termination of employment, reduction in work hours, or end of COBRA or state continuation.

MEDICAL COVERAGE

□ **Option #1 – PPO**

Coverage Options	Monthly Deduction
□ Employee Only	$155.00/ Per paycheck
□ Employee & Spouse	$535.00/ Per paycheck
□ Employee & Child(ren	$460.00/ Per paycheck
□ Employee & Family	$715.00/ Per paycheck

□ **Option #2 – HSA (HDHP) Plan**

Coverage Options	Monthly Deduction
□ Employee Only	$ 55.00/ Per paycheck
□ Employee & Spouse	$385.00/ Per paycheck
□ Employee & Child(ren	$310.00/ Per paycheck
□ Employee & Family	$565.00/ Per paycheck

□ **Option #3 – Waive Medical Coverage – I am waiving medical coverage for the following reason:**

- □ Covered under spouse's plan
- □ Covered under another plan – Medicare, Tricare
- □ Other

DENTAL AND VISION COVERAGE

□ **DENTAL**

Coverage Options	Monthly Deduction
□ Waive all Dental Coverage	
□ Employee Only	$0/ Per paycheck
□ Employee & Spouse	$37.99/ Per paycheck
□ Employee & Child(ren	$43.67/ Per paycheck
□ Employee & Family	$104.31/ Per paycheck

□ **VISION**

Coverage Options	Monthly Deduction
□ Waive all Vision Coverage	
□ Employee Only	$0/ Per paycheck
□ Employee & Spouse	$ 6.96/ Per paycheck
□ Employee & Child(ren	$ 7.94/ Per paycheck
□ Employee & Family	$16.84/ Per paycheck

I declare that I have been given the opportunity to apply for group medical, dental and vision coverage or I am now revoking my previous election for group medical, dental and vision coverage offered by D49. I understand the coverage available and I refuse coverage.

DEPENDENT & SPOUSE INFORMATION

List all eligible dependents and spouse for which you would like coverage:

Name			Date of Birth	Sex	Relationship	SS #	Medical Coverage	Dental Covera	Vision Coverage
Last	First	MI	MM/DD/YYYY	M/F			Check if coverage elected		

All employees will be required to provide proof for each dependent covered on their plan that they are eligible dependents. The following is the acceptable documentation. For Spouse: marriage license, common law marriage affidavit or IRS Tax forms showing joint filing status (you can black out figures). For child(ren): **1)** Natural born children – copy of birth certificate for each dependent; 2) Step children – copy of birth certificate for each dependent AND marriage license/common law marriage affidavit/IRS Tax Form showing joint filing status; 3) Adopted children – adoption papers; and 4) Children you have legal guardianship of – court documentation showing that you are the legal guardian. Attach documentation to the enrollment form. **Spouse/Dependent Coverage will not be effective until all supporting documentation is submitted.**

If you are canceling a dependent, please provide name of individual(s): _____

Life Beneficiary Designation

Primary Beneficiary:
Name:_____
Relationship:_____SS#:_____
Address:_____

Secondary Beneficiary Info (only if primary beneficiary is deceased)
Name:_____
Relationship:_____SS#:_____
Address:_____

EMPLOYEE AUTHORIZATION

I understand that my salary will be reduced each payroll period by the appropriate elected amount(s).

I understand and agree that:

1. My election cannot be revoked or changed before December 31, 2024, unless there is a change in my family status (as defined in the plan document) that justifies the revocation or change as provided by the regulations under the Internal Revenue Code.
2. D49 reserves the right to cancel or amend the Plan.
3. This election is subject to such additional requirements as set forth in the Plan.
4. I authorize deduction from my wages if necessary for the required premium for the coverage for which I or any dependents have applied.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.

I understand that the coverage I am applying for is subject to eligibility requirements. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between our benefit carriers and me.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Confirmation:_____ **Date:**_____

Type your full name as an Enrollment Confirmation

PLEASE COMPLETE, SIGN, DATE AND RETURN TO HUMAN RESOURCES