



Butte Schools Self-Funded Programs
Healthy Employees Supported by Quality, Well-Managed Programs
EMPLOYEE BENEFIT PLAN APPLICATION / CHANGE FORM



EMPLOYEE NAME (Last, first, MI)	Home Phone # () - -	Social Security #	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Mailing Address: _____ Single Married Registered Domestic Partnership

EMPLOYER	Date of Hire / /	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Administration / Management <input type="checkbox"/> Confidential	<input type="checkbox"/> Certificated <input type="checkbox"/> Classified	<input type="checkbox"/> School Board Member
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APPLICATION TYPE

New enrollment at date of hire

Transfer from another BSSP District: _____

Re-enrollment due to court order or loss of other coverage (attached copy)

Re-enrollment due to insured change

Name change. Former name: _____

Surviving spouse. Decedent's name/SSN: _____

New address

Dependent change

Termination of employment

Voluntary disenrollment: I understand that I may re-enroll in a BSSP plan only at the time of a change in my total work hours or work year.
 _____ (initials)

Declination of coverage at initial eligibility date (part-time employees and school board members, only): I decline coverage at this time. I understand I may only elect coverage during a future BSSP open enrollment period (May 1-May 31 effective July 1) or within 31 days of a change in my total work hours or work year. _____ (initials)

DEPENDENT CHANGE (Indicate changes under "Eligible Dependent(s)" below.)

Add child at birth. Delete spouse/partner

Add child due to other qualifying event. Delete child

Qualifying event and date: _____ Not applicable

Add spouse/registered domestic partner. Date of qualifying event: _____

OTHER COVERAGE

1. Are you or your dependents currently covered under another medical plan?
 Yes, BSSP Yes, other coverage No. If no, you do not need to complete 2., 3. and 4., below.
 Employer: _____ Phone: _____
 Carrier / Policy / ID#: _____

2. If yes, who is covered? Self Spouse/Partner Children

3. Is your spouse/partner a full-time employee with an option of employer-paid benefits? Yes No

4. Does your spouse's/partner's employer offer a medical plan for your spouse/partner that costs \$100 or less per month? Yes No

When 3. and 4. above are "YES", your spouse/partner needs to enroll in his/her employer's minimum employee-only insurance plan or BSSP will coordinate his/her benefits with a \$250 deductible and 80% copayment.

ELECTED COVERAGE	Medical: <input type="checkbox"/> Option I -- Silver <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Option II <input type="checkbox"/> Declined	Dental: <input type="checkbox"/> Yes <input type="checkbox"/> Declined	Vision: <input type="checkbox"/> Yes <input type="checkbox"/> Decline	Life: <input type="checkbox"/> Yes <input type="checkbox"/> Declined If yes, complete separate enrollment form. Supplemental employee: <input type="checkbox"/> \$0 <input type="checkbox"/> \$ _____ Supplemental spouse: <input type="checkbox"/> \$0 <input type="checkbox"/> \$ _____ Supplemental dependent (birth to age 25): <input type="checkbox"/> Yes <input type="checkbox"/> No
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ELIGIBLE DEPENDENT(S) (Legal spouse, registered domestic partner and/or children claimed as a dependent on your tax return. See Summary Plan Description booklet for definition of eligible dependents. Spouse/partner: attached a copy of your marriage/ registered domestic partnership certificate. Children: attach a copy of birth certificate, adoption papers, etc.)

Add / Drop	Relationship	Last, first, MI	Date of Birth	Certificate attached?	Social Security #	Coverage
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Spouse <input type="checkbox"/> Partner		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /		- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

PLEASE READ CAREFULLY

- Authorization to obtain or release medical information: Butte Schools Self-Funded Programs (BSSP) is authorized to obtain and release medical information in compliance with HIPAA and any other insurance and privacy protection act.
- I hereby authorize my physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish an agent, designee or representative of Anthem Blue Cross, Delta Dental, VSP, Medco or BSSP any and all records of medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation or evaluation of an application or a claim.
- I authorize BSSP or its agents, designees or representative to disclose to a hospital, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of the claim.
- This authorization shall become effective immediately and shall remain in effect as long as necessary to enable BSSP to process claims and establish rates.
- I understand I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- I understand any dispute between myself (and/or enrolled family member) and Anthem Blue Cross, Delta Dental, VSP, Medco or any affiliate, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the small claims court and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage the member and Anthem Blue Cross, Delta Dental or VSP are giving up the right to have any dispute decided in a court of law before a jury.
- My spouse/partner's employer may be contacted to verify coverage.

I DECLARE, UNDER PENALTY OF PERJURY AND THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT. I WILL REPAY ANY CLAIMS PAID FRAUDULENTLY ON BEHALF OF MYSELF, MY SPOUSE/PARTNER AND/OR MY DEPENDENT CHILDREN.

Signature: _____ Date: _____

TO BE COMPLETED BY HR / PAYROLL					
HIPAA / COBRA Qualifying Event: Date of event: _____ <input type="checkbox"/> Reduction in hours / work year <input type="checkbox"/> Termination of employment <input type="checkbox"/> Death of employee <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Loss of overage-age-dependent status	Medical Group	Dental Group	Vision Group	Life Group	Voluntary Life Group
	Effective Date / /	Effective Date / /	Effective Date / /	Effective Date / /	Effective Date / /
	Notes: _____				
HR/Payroll Signature: _____					Date: _____