COLUMBIA FALLS SCHOOL DISTRICT #6 ENROLLMENT FORM Group #0000162	Coverage Effective Date:

Employee Information and Benefit Election

Last Name	First Name	MI	Gender	Date of Birth

Social Security #: Employment Date:	Marital Status: Single Married Divorced Separated

Current Mailing Address: Street: **City:** **State:** **Zip:**

Home Phone: ( ) **Work Phone: ( )** **(ext)** **E-mail address:** **Job Position:**

MEDICAL PLAN ELECTION: ☐ **Single** ☐ **Family** ☐ **No Coverage (please sign declination on page 2 and complete waiver form)**

☐ **Initial Enrollment Period** ☐ **Annual Enrollment Period** ☐ **Special Enrollment (if loss of eligibility for other coverage please provide date of loss & reason for loss)**

ACTIVE EMPLOYEE LIFE/AD&D INSURANCE: ☐ $20,000 Life / $20,000 AD&D Coverage reduces at ages 65, 70, 75 and 80	ACTIVE EMPLOYEE DEPENDENT LIFE/AD&D: ☐ $2,000 Life / $2,000 AD&D	Note to couples who are both employees: if you are covered as an employee for Life/AD&D you are not eligible as a dependent for dependent life.

Life/AD&D Beneficiary Name:	Relationship:	*If you are married and name a beneficiary other than your spouse, your spouse must sign the following acknowledgment.* I acknowledge that I am the spouse of _____ and that I am aware that he/she has designated a person(s) other than me as the beneficiary(ies) and that any amounts due my spouse at the time of his/her death related to the life/AD&D insurance will be paid to the beneficiary(ies) listed. **Spouse signature** _____

Please List all Eligible Dependents to be Covered (legal spouse and children under age 26)

Last Name	First Name	MI	Social Security Number	Gender	Date of Birth	Relationship

Signature Required on Back →

Other Health Benefit Plan Coverage Information

If you or any of your dependents are enrolled in another health benefit plan or other health insurance coverage, please complete the following information for each person, in order to coordinate benefits with other health benefit plans.

Last Name	First Name	Other Health Benefit Plan Name, Policy Number, Address and Phone	Medicare	Medical	Dental

If your dependent children are covered under another health benefit plan, please list the Policyholder's name and date of birth below.

Other Policyholder name:	Other Policyholder date of birth:

Acceptance or Declination of Coverage – Signature Required

Application is made for benefits under the Columbia Falls School District #6 benefit plan for which I am eligible. I certify the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the plan. By signing the acceptance below I authorize Columbia Falls School District to deduct any required contribution from my salary or wages on a pre-tax basis.

Acceptance: If you accept coverage please sign and date below. **(This form is valid only if signed and dated.)**	**Declination:** If you decline coverage for yourself and your dependents, please sign and date below.
Applicant Signature _____ **Date** _____	**Applicant Signature** _____ **Date** _____

For Third Party Administrator or Office Use Only: **Entered by:** **Date of Entry:** **ID Card?** ☐ **Yes** ☐ **No**

Certificate of Creditable Coverage attached? ☐ **Yes** ☐ **No**

Columbia Falls School District #6 Change Request Form — Group #0000162

Employee Name: | **Employee ID Number:**

Employment Date: | **Original Coverage Effective Date:** | **Job Position:**

Change Name: | **Change Address:**

Change Marital Status: Single Married Divorced Separated | **Change Employment Status:** Full-Time Part-Time Approved Leave

Add Spouse: Name:
Date of birth: **SSN:**
Medical ☐ **Dependent Life** ☐ **Vision** ☐ **Dental** ☐
Reason: **Effective Date:**

Delete Spouse: Name:
Date of birth:
Reason: **Effective Date:**

Add Child: Name:
Date of birth: **SSN:**
Medical ☐ **Dependent Life** ☐ **Vision** ☐ **Dental** ☐
Reason: **Effective Date:**

Delete Child: Name:
Date of birth:
Reason: **Effective Date:**

Certificate of Creditable Coverage: **Is attached for consideration** **To be sent** **Does not apply**

Change Life/AD&D Beneficiary: Name: **Relationship:**

If you are married and name a beneficiary other than your spouse, your spouse must sign the following acknowledgment. I acknowledge that I am the spouse of _____ and that I am aware that he/she has designated a person(s) other than me as the beneficiary(ies) and that any amounts due my spouse at the time of his/her death related to the life/AD&D insurance will be paid to the beneficiary(ies) listed. **Spouse signature** _____

I certify the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the Plan.

Applicant Signature: **Date:**

For Third Party Administrator Office Use Only: **Entered by:** **Date of Entry:** **ID Card?** ☐ **Yes** ☐ **No**

Columbia Falls School District #6 Waiver Form **Group #0000162**

Employee Name: _____ **Employment Date:** _____

I have been offered coverage under the Columbia Falls School District Health Benefit Plan. I am waiving coverage for the following reason(s). Check all that apply:

☐ I do not wish to enroll myself and/or my dependents in the Columbia Falls School District Health Benefit Plan at this time.

☐ I and/or my dependents currently have medical coverage elsewhere:

Carrier name _____ Policy Number _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ Medicaid ☐ TriCare ☐ Indian Health
☐ Other _____

If you are waiving coverage under the Columbia Falls School District Health Benefit Plan for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents under the Columbia Falls School District Health Benefit Plan if you or your dependents lose eligibility for the other coverage (or an employer stops contributing towards that other coverage) provided that you request enrollment within 30 days after the other coverage ends (or employer contributions stop). In addition, if you waive enrollment at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under the Plan provided that you submit an enrollment form within 30 days after the marriage, or within 30 days after the birth, adoption, or placement for adoption.

I understand that I and/or my dependents will be unable to obtain coverage under the Columbia Falls School District Health Benefit Plan except during a special enrollment period as explained above, or during the designated annual enrollment period.

_____ _____

Signature of Employee **Date**