

SHADED AREAS TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER <b>BLOOMINGTON PUBLIC SCHOOLS ISD #271</b>		GROUP NUMBER <b>PCH 10109</b>	CLASS	NETWORK	SUBGROUP	PLAN
<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/return <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Retiree <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Early Retiree <input type="checkbox"/> Special Enrollment: Date _____		<input type="checkbox"/> COBRA (Begin Date) _____	QUALIFYING EVENT		Date of Full-Time Employment Month _____ Day _____ Year _____	Coverage Effective Date Month _____ Day _____ Year _____
<input type="checkbox"/> Termination/reduction in work hours <input type="checkbox"/> Employer Contributions terminated <input type="checkbox"/> Divorce / legal separation <input type="checkbox"/> Death <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage						

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH Month _____ Day _____ Year _____	SOCIAL SECURITY NUMBER
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STREET ADDRESS/APT. NO.	CITY	STATE	ZIP
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EMPLOYEE'S TELEPHONE HOME ( ) _____ BUSINESS ( ) _____	E-MAIL ADDRESS	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
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Do you or any family members listed below have other coverage in addition to this plan?  NO  YES - Type:  Medical  Dental  
 If yes, name(s) \_\_\_\_\_  Single coverage or  Family coverage  
 Name of insurance company \_\_\_\_\_

Are you covered by or eligible for Medicare Part A or B?  NO  YES - (Attach a copy of Medicare card) Effect. date: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Are you covered by Medicare Part D?  NO  YES - effective date of Part D \_\_\_\_\_

Is your spouse and/or dependent covered by or eligible for Medicare Part A or B?  NO  YES - (Attach a copy of Medicare card) Effect. date: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Is your spouse and/or dependent covered by Medicare Part D?  NO  YES - effective date of Part D \_\_\_\_\_

I ACCEPT COVERAGE FOR:  Medical:  Self  Spouse  Children  Dental:  Self  Spouse  Children

**FILL IN THE FOLLOWING INFORMATION FOR EACH ELIGIBLE DEPENDENT TO BE COVERED**

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH			SOCIAL SECURITY NO.
					Month	Day	Year	

Do all of the dependent(s) listed above reside at the same address as the employee?  YES  NO

If no, list dependent(s) name and address \_\_\_\_\_

If last name is different for dependents, please explain why \_\_\_\_\_

Are any of the above listed dependent(s) age 19 or older, students?  YES  NO If YES, please indicate the name, school attending and status

NAME	SCHOOL	STATUS
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time

Are any age 19 or older dependents listed above incapable of self-sustaining employment because of physical or mental handicap and dependent on the employee for a majority of their financial support?  YES  NO. If YES, date of onset of physical or mental handicap \_\_\_\_\_

**If yes, please provide supporting documentation.**

I DECLINE COVERAGE  Medical  Dental DUE TO:  Other coverage  Other reason \_\_\_\_\_

If you are declining major medical expense coverage for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request coverage within 31 days after you or your dependent's other coverage ends or the employer stops contributing to the coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependent and spouse, provided that you request enrollment within 31 days after marriage, birth, adoption, or placement for adoption.  
 I freely and voluntarily decline coverage as indicated above.

Date: \_\_\_\_\_ Employee Signature (if declining coverage): \_\_\_\_\_

I represent that the answers to the questions and statements made on this form are true and complete.

On behalf of myself and my enrolled dependents, I authorize any physician, medical practitioner, hospital, clinic, veterans' administration facility, or other medically related facility who has treated me and/or my dependents enrolled on this form, to release to PreferredOne Administrative Services, Inc. (acting for and on behalf of its self-funded plan clients or its affiliates PreferredOne Community Health Plan or PreferredOne Insurance Company) information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me (or, if requested, my enrolled dependents) for insurance underwriting and plan administration purposes. This authorization excludes the release of information about HIV (AIDS virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; 2) to a patient who received the services of emergency medical personnel at a hospital or medical facility; or 3) to emergency medical personnel who were tested as a result of performing emergency medical services. This authorization also excludes psychotherapy notes.

This authorization shall remain valid as long as I am continually covered by the medical and/or dental coverage in which I am enrolling with this form. I agree that a copy of this authorization shall be valid as the original. Information released pursuant to this authorization is released to an entity subject to the Health Insurance Portability and Accountability Act (HIPAA). This authorization may be revoked by submitting a written revocation to PreferredOne Customer Service. Such revocation will not effect actions taken prior to the revocation. Because this authorization is for underwriting, risk rating, and enrollment purposes, revocation of this authorization or failure to give this authorization may result in denial or termination of coverage.

I understand that I must update this form and resubmit it if anything changes that affects the information on this form between submission of the form and effective date of coverage. **I understand that providing false information or omission of relevant information on this form may result in denial of claims, cancellation of coverage, or an increase in premiums, and may be considered insurance fraud.** I understand that, subject to the terms and conditions of the certificate of coverage or plan under which I am enrolling for coverage, I may be subject to a pre-existing condition limitation.

<b>X</b>	Month _____ Day _____ Year _____	<b>X</b>	Month _____ Day _____ Year _____
SIGNATURE OF EMPLOYEE (if applying for coverage)	DATE SIGNED	SIGNATURE OF EMPLOYER (Required)	DATE SIGNED

EMPLOYEE - COMPLETE ALL UNSHADED AREAS.