

Insurance Enrollment Form  
**Washington County School District**

New Enrollee   
 Change Form

Effective Date of Coverage / Change \_\_\_\_\_

Employee Information				
Social Security Number - -	Last Name	First Name	Middle Initial	
Address	City	State	Zip	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth / /	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced / Widowed		Home Phone	
Employer	Job Title	Hours Worked	Date of Employment / /	

Enrolling Members				
Relationship to Insured	Last Name, First Name	Gender	Date of Birth MM/DD/YYYY	Social Security Number
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -

*If you have more than 5 dependents, please attach a piece of paper listing these elements of information regarding each individual dependent.*

Coverage Elections				
<input type="checkbox"/> <b>Medical:</b> EMI HDHP with HSA Plan	I am applying for:		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + Two or More Dependents	
<input type="checkbox"/> <b>Medical:</b> EMI (Traditional) Plan	I am applying for:		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + Two or More Dependents	
<input type="checkbox"/> <b>Dental:</b> EMI	I am applying for:		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + Two or More Dependents	
<input type="checkbox"/> <b>Basic Life Insurance and AD&amp;D:</b> LifeMap			<input type="checkbox"/> Change of Beneficiary Only	
Primary Beneficiary Name	Address	SSN	Relationship	% of Benefit
Contingent Beneficiary Name	Address	SSN	Relationship	% of Benefit
<input type="checkbox"/> <b>Health Savings Account (HSA):</b> HealthEquity		Per Payroll Election: _____		
WCS D contributes \$80 per month. If you elect to contribute at least \$20 to your HSA, the District will contribute an additional \$20 (for a total of \$120 per month).				
$\frac{\$80}{\text{WCS D Monthly Contribution}} + \frac{\$20}{\text{Employee Contribution}} + \frac{\$20}{\text{WCS D Employee Match}} = \$120/\text{mo } (\$1,440/\text{year})$				
Group Medical, Dental, and Basic Life Insurance Premium Deductions are Automatic				

Continued on the other side

Insurance Enrollment Form Continued  
**Washington County School District**

COBRA		
Notify employer within 30 days of any change (marriage, first birth, divorce, etc.)		
Event:	<input type="checkbox"/> Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Reduced Hours <input type="checkbox"/> Leave of Absence	<input type="checkbox"/> Divorce / Separation <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Death <input type="checkbox"/> Ineligible Dependent
		<input type="checkbox"/> Term / Retirement / Medicare <input type="checkbox"/> State Continuation <input type="checkbox"/> New Hire
Event Date	Qualified Beneficiary	

Waiver of Coverage – Please Check All That Apply	
<p>I have been given the opportunity to enroll in the Washington School District Employee Benefits, and hereby waive my right to enroll in the following coverage. I understand that my dependents and I may not again be eligible to enroll in these programs until the next enrollment period established by Washington County School District or in the event of a qualifying event.</p>	
I am waiving: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	I do not want coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> My Dependents <input type="checkbox"/> My Spouse
Reason for Waiver	
Signature	Date

Agreement and Authorization	
<p>I hereby apply for membership with EMI Health for the persons listed on this enrollment form (collectively referred to as Enrolled Family). I understand that my enrollment and benefits are in accordance with a described in the applicable Evidence of Coverage and Group Service Agreement. I authorize 1) all health providers and insurers to furnish EMI Health, and 2) all health providers and EMI Health to furnish all insurers and health providers records concerning me or any member of my Enrolled Family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative may receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through EMI Health. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for 30 months from the date the authorization is signed.</p> <p>I understand that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage until the next open enrollment period, which is established by my employer and EMI Health. I also understand that unless I am declining enrollment for myself and my dependent(s) (including my spouse) because of other health insurance coverage, I may be subject to a pre-existing condition waiting period of up to 12 months, as specified by EMI Health. If I am waiving because I have other insurance, I realize that I may in the future be able to enroll myself and any dependent(s), provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.</p> <p>By signing this form, I agree on behalf of myself and my Enrolled Family that EMI Health may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in the EMI Health Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and my Enrolled Family, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness including substance abuse, AIDS, ARC, or HIV to EMI Health for administration of Health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.</p> <p>I have read and agree to the statements above.</p>	
Signature	Date

Employer Use Only	
Eligibility Date	Date of Hire
Plan Effective Date	Approved By