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 ☐ M ☐ F
Date of Birth / /	Marital Status ☐ Single ☐ Married ☐ 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
		☐ M ☐ F	/ /	- -
		☐ M ☐ F	/ /	- -
		☐ M ☐ F	/ /	- -
		☐ M ☐ F	/ /	- -
		☐ M ☐ F	/ /	- -
		☐ M ☐ F	/ /	- -
		☐ M ☐ 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

☐ **Medical:** EMI HDHP with HSA Plan — I am applying for:
- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + Two or More Dependents

☐ **Medical:** EMI (Traditional) Plan — I am applying for:
- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + Two or More Dependents

☐ **Dental:** EMI — I am applying for:
- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + Two or More Dependents

☐ **Basic Life Insurance and AD&D:** LifeMap
- ☐ Change of Beneficiary Only

Primary Beneficiary Name	Address	SSN	Relationship	% of Benefit

Contingent Beneficiary Name	Address	SSN	Relationship	% of Benefit

☐ **Health Savings Account (HSA):** HealthEquity — **Per Payroll Election:** _____

WCSD 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).

$80 (*WCSD Monthly Contribution*) + $20 (*Employee Contribution*) + $20 (*WCSD Employee Match*) = $120/mo *($1,440/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:

- ☐ Termination
- ☐ Retirement
- ☐ Reduced Hours
- ☐ Leave of Absence
- ☐ Divorce / Separation
- ☐ Loss of Coverage
- ☐ Death
- ☐ Ineligible Dependent
- ☐ Term / Retirement / Medicare
- ☐ State Continuation
- ☐ New Hire

Event Date	Qualified Beneficiary

Waiver of Coverage – *Please Check All That Apply*

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 for 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.

I am waiving:

- ☐ Medical
- ☐ Dental

I do not want coverage for:

- ☐ Myself
- ☐ My Dependents
- ☐ My Spouse

Reason for Waiver	
Signature	**Date**

Agreement and Authorization

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.

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.

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.

I have read and agree to the statements above.

Signature	Date

Employer Use Only

Eligibility Date	Date of Hire
Plan Effective Date	**Approved By**