ASBA Insurance Trust *DISTRICT NAME:* **Nogales Unified School District** *GROUP #:* **13712**

**2022-2023**
**BENEFIT ENROLLMENT/ CHANGE FORM**

**PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM**

**PRE-TAX** ☐ Yes ☐ No (If Yes, must have Qualifying Event to make mid-year change)

## EMPLOYEE INFORMATION – To be completed by the employee only

| LAST NAME | FIRST NAME | MI | DATE OF BIRTH (MM/DD/YY) |
|---|---|---|---|
| | | | / / |

| SOCIAL SECURITY NO. | GENDER | MARITAL STATUS | STATUS OF MEMBER |
|---|---|---|---|
| | ☐ M ☐ F | ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner | ☐ Active Employee ☐ Cobra ☐ Retiree |

| HOURS WORKED PER WEEK | ADDRESS CHANGE | NAME CHANGE |
|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ No If yes, previous name? _____ |

MAILING ADDRESS

| CITY | STATE | ZIP |
|---|---|---|
| | | |

| HOME PHONE NUMBER | WORK PHONE NUMBER |
|---|---|
| | |

ARE YOU THE **EMPLOYEE** COVERED UNDER **ANY** OTHER INSURANCE? ☐ YES ☐ NO (i.e. Medicare, Tricare, spouse's plan)

IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____

TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____

IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____

ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)

## TO BE COMPLETED BY HUMAN RESOURCES ONLY

(if this section is not complete, form will be returned to the district)

☐ NEW HIRE
Hire Date ____/____/____
Effective Date____/____/____

☐ TERMINATION OF INSURANCE

☐ CHANGE
Effective Date of Change____/____/____
Date of Qualifying Event ____/____/____

☐ ADD/TERM DEPENDENT(S)
Qualifying Event_____

☐ LEAVE OF ABSENCE
Start Date ____/____/____

☐ OPEN ENROLLMENT

☐ RETIREE
Effective Date ____/____/____

SALARY $_____

HR INITIALS_____ DATE____/____/____

## DECLINATION OF ENROLLMENT

☐ I WISH TO WAIVE COVERAGE Are you currently covered by other health insurance? ☐ Yes ☐ No

| EMPLOYEE SIGNATURE | DATE |
|---|---|
| | / / |

## BENEFIT SELECTION

| | | | | |
|---|---|---|---|---|
| ☐ ACTIVE: COPAY GOLD | ☐ EMPLOYEE ONLY | ☐ EMPLOYEE + SPOUSE/PARTNER | ☐ EMPLOYEE + CHILD(REN) | ☐ EMPLOYEE + FAMILY |
| ☐ ACTIVE: CLASSIC GOLD | ☐ EMPLOYEE ONLY | ☐ EMPLOYEE + SPOUSE/PARTNER | ☐ EMPLOYEE + CHILD(REN) | ☐ EMPLOYEE + FAMILY |
| ☐ ACTIVE: HDHP A | ☐ EMPLOYEE ONLY | ☐ EMPLOYEE + SPOUSE/PARTNER | ☐ EMPLOYEE + CHILD(REN) | ☐ EMPLOYEE + FAMILY |
| ☐ RETIREE: VALUE GOLD | ☐ RETIREE ONLY | ☐ RETIREE + SPOUSE/PARTNER | ☐ RETIREE + CHILD(REN) | ☐ RETIREE + FAMILY |
| ☐ RETIREE: HDHP A | ☐ RETIREE ONLY | ☐ RETIREE + SPOUSE/PARTNER | ☐ RETIREE + CHILD(REN) | ☐ RETIREE + FAMILY |

| | |
|---|---|
| ☐ IMS MEXICO NETWORK-VOLUNTARY | ☐ YES ☐ NO |

## DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

***Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP).*** If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:
a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or
b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

| DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE) | SOCIAL SECURITY NO. (REQUIRED) | RELATIONSHIP (REQUIRED) | DATE OF BIRTH (MM/DD/YY) | GENDER (M/F) | DISABLED DEPENDENT* | FULL-TIME STUDENT** | MARRIED** |
|---|---|---|---|---|---|---|---|
| , , | | | / / | ☐ M ☐ F | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| , , | | | / / | ☐ M ☐ F | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| , , | | | / / | ☐ M ☐ F | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| , , | | | / / | ☐ M ☐ F | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| , , | | | / / | ☐ M ☐ F | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |

*If your child is mentally or physically disabled, please provide appropriate documentation.
**Please note: You must check YES or NO for the Married and Full-Time Student columns above if enrolling in ASBAIT dental and/or vision benefits.

***DISTRICT NAME:*** **Nogales Unified School District**

## **COORDINATION OF BENEFITS** – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF **YES**, ☐FULL TIME ☐PART TIME SPOUSE EMPLOYER: SPOUSE DATE OF BIRTH: / /

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

| TYPE OF OTHER COVERAGE | CARRIER NAME | CARRIER ADDRESS | EFFECTIVE DATE (MM/DD/YY) | TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA) | LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN |
|---|---|---|---|---|---|
| ☐MEDICAL | | | / / | | |
| ☐PRESCRIPTION | | | / / | | |
| ☐DENTAL | | | / / | | |
| ☐VISION | | | / / | | |

## **COORDINATION OF BENEFITS** – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐YES ☐NO

EMPLOYER PROVIDING COVERAGE: IF **YES**, COMPLETE THE QUESTIONS BELOW

| TYPE OF OTHER COVERAGE | CARRIER NAME | CARRIER ADDRESS | EFFECTIVE DATE (MM/DD/YY) | TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA) | COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)* | LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN |
|---|---|---|---|---|---|---|
| ☐MEDICAL | | | / / | | | |
| ☐PRESCRIPTION | | | / / | | | |
| ☐DENTAL | | | / / | | | |
| ☐VISION | | | / / | | | |

***COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.**

## **COORDINATION OF BENEFITS** – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID,TRICARE, MICHILD, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐YES ☐NO IF **YES**, PLEASE COMPLETE BELOW

| LIST ALL FAMILY MEMBERS ENROLLED | TYPE OF COVERAGE | EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE | PART B EFFECTIVE DATE (IF APPLICABLE) | HICN | IS MEDICARE COVERAGE DUE TO: |
|---|---|---|---|---|---|
| | | / / | / / | | ☐AGE ☐DISABILITY ☐ESRD |
| | | / / | / / | | ☐AGE ☐DISABILITY ☐ESRD |

## PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

## NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

## SIGNATURE AND AUTHORIZATION

| EMPLOYEE SIGNATURE | PRINT EMPLOYEE NAME | DATE |
|---|---|---|
| | | |