



Kenai Peninsula Borough School District Health Care Plan Participant Enrollment Form



EMPLOYEE INFORMATION

Name of Employee:			Date of Enrollment or Change:		
Social Security Number:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	IHS (Indian Health Services) Eligible: <input type="checkbox"/> Y <input type="checkbox"/> N		
Address:			Date of Birth:		
City:	State:	Zip:	Marital Status:		
Phone:	Email:		Date of Marriage:		

TYPE OF ENROLLMENT/LEGAL DOCUMENTATION

Legal documentation is required for all new enrollments and any changes made:

☐ New Enrollment ☐ Open Enrollment ☐ Change in Status

☐ DECLINING COVERAGE (Note: You may decline only if you have other health coverage outside KPBSD that meets the minimum Affordable Care Act requirements.)

Reason for electing, changing or declining coverage: _____

☐ I wish to DECLINE Dental/Vision coverage (I understand this will NOT reduce/change my contribution amount)

COVERAGE AND DEPENDENT INFORMATION

One plan option must be selected:

☐ Traditional Plan ☐ HDHP Plan (Note: You may choose to opt-out of HRA reimbursements by contacting the Benefits Manager)

Add	Drop	Relationship to Employee	Last Name	First Name	Middle Initial	IHS Eligible	Social Security No.	Date of Birth	Employer	Gender
<input type="checkbox"/>	<input type="checkbox"/>	SPOUSE				<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> M <input type="checkbox"/> F

Is any child over the dependent age limit applying for coverage due to disability? ☐ No ☐ Yes → Complete the Request for Certification of Disabled Dependent form.

Does any dependent have a different mailing address? ☐ No ☐ Yes → _____

List Dependent name

Write in Dependent mailing address including City, State and ZIP Code

OTHER COVERAGE INFORMATION

Do you, your spouse and/or your covered dependents have other coverage for: If yes, please attach a Certificate of Creditable Coverage from your current carrier(s) – Certificates only apply to newly enrolled Employees & Dependents.

Medical ☐ No ☐ Yes Dental ☐ No ☐ Yes Vision ☐ No ☐ Yes Prescriptions ☐ No ☐ Yes Medicare ☐ No ☐ Yes

COVERAGE #1:

Enrollee's Name: _____ Enrollee's Birth Date: _____ Plan Name: _____

ID #: _____ Effective Date: _____ Individuals currently covered under this policy: _____

COVERAGE #2:

Enrollee's Name: _____ Enrollee's Birth Date: _____ Plan Name: _____

ID #: _____ Effective Date: _____ Individuals currently covered under this policy: _____

SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF MEDICAL INFORMATION OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND FOR MY DEPENDENTS, AND THAT I WILL BE GUILTY OF INSURANCE FRAUD. I authorize deductions, if any, from any earnings toward the cost of the coverage. A copy of this authorization shall be as valid as the original.

Sign Here → _____

Employee's Signature

Print Name

Date

THIS SECTION TO BE COMPLETED BY EMPLOYER

Exact date of full-time employment:			Effective Date:			Date Processed:			
Month	Day	Year	Month	Day	Year	Month	Day	Year	Plan Administrator