

COMPLETE ALL INFORMATION IN THIS SECTION											
YOUR INFORMATION	EMPLOYEE'S FIRST NAME		LAST NAME			MI	SEX	BIRTHDATE		MARITAL STATUS	
	HOME ADDRESS							CITY		STATE	ZIP CODE
	SOCIAL SECURITY #			HOME PHONE NUMBER			PREFERRED EMAIL ADDRESS			EFFECTIVE DATE (HIRE/STATUS CHANGE)	

WAIVE COVERAGE (OPT-OUT)	
SELECT YOUR COVERAGE	<p><b>YOU MAY ELECT OPT-OUT OF INSURANCE BENEFITS. INSURANCE REGULATIONS REQUIRE THAT ALL EMPLOYEES SELECTING THE INSURANCE OPT-OUT ACKNOWLEDGE THEY ARE WAIVING COVERAGE ANNUALLY AND PROVIDE CURRENT PROOF OF OTHER INSURANCE COVERAGE.</b></p> <p><small>YOUR ELECTION TO OPT-OUT IS REQUIRED ANNUALLY AND FAILURE TO RENOTIFY THE PLAN EACH YEAR WILL RESULT IN THE FORFEITURE OF ANY OPT-OUT COMPENSATION. TO BE ELIGIBLE, YOU MUST ACKNOWLEDGE BELOW AND RETURN THIS SIGNED FORM ALONG WITH PROOF OF OTHER COVERAGE TO THE TREASURER'S OFFICE NO LATER THAN THE END OF OPEN-ENROLLMENT FOR THE UPCOMING SCHOOL YEAR. CONSULT YOUR UNION AGREEMENT FOR FURTHER DETAILS.</small></p> <p><b>I HEREBY ACKNOWLEDGE THAT I AM WAIVING ALL MEDICAL, PRESCRIPTION AND DENTAL BENEFITS FOR THE UPCOMING PLAN YEAR AND WILL NOT BE ABLE TO CHANGE THIS ELECTION WITHOUT A QUALIFIED CHANGE OF STATUS OR UNTIL THE NEXT OPEN ENROLLMENT. I UNDERSTAND THAT THE COUNTY MUST BE NOTIFIED WITHIN 31 DAYS OF ANY QUALIFIED EVENT.</b></p> <p style="text-align: center;"><b>YOU MUST SUBMIT PROOF OF OTHER COVERAGE AND ACKNOWLEDGE THE ABOVE INFORMATION BY SIGNING HERE -&gt;</b> _____</p>

ENROLL IN COVERAGE		
<p><b>SELECT YOUR COVERAGE AND BENEFIT OPTIONS</b></p> <p><small>IF ENROLLING IN COVERAGE, SELECT THE LEVEL OF COVERAGE BELOW. FAMILY RATE APPLIES TO SINGLE+SPOUSE, SINGLE+CHILD(ren) AND FULL FAMILY ENROLLEES.</small></p>		
<p><b>MEDICAL</b></p> <p><input type="radio"/> SINGLE</p> <p><input type="radio"/> FAMILY</p>	<p><b>VISION</b></p> <p><input type="radio"/> SINGLE</p> <p><input type="radio"/> FAMILY</p>	<p><b>DENTAL</b></p> <p><input type="radio"/> SINGLE</p> <p><input type="radio"/> FAMILY</p>

COMPLETE INFORMATION BELOW FOR ANY DEPENDENTS YOU ARE INSURING														
PLEASE BE SURE TO REVIEW YOUR PLAN'S DESCRIPTION OF ELIGIBLE DEPENDENTS. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME AND WILL RESULT IN IMMEDIATE RECISSION OF COVERAGE AND LEGAL ACTION.														
PARTICIPANT ENROLLMENT INFORMATION	SP=SPOUSE CH=CHILD SCH=STEP CHILD	MEMBER TYPE	FIRST NAME	LAST NAME	MI	GENDER	SOCIAL SECURITY #	DATE OF BIRTH	IS THIS DEPENDENT CURRENTLY WORKING FULLTIME?	IF EMPLOYED, DOES THEIR EMPLOYER OFFER HEALTHCARE?	IF THEY OFFER HEALTHCARE, IS THIS DEPENDENT ENROLLED?	SELECT TO ENROLL		
	MEDICAL	VISION	DENTAL											

PRIOR COVERAGE																
PRIOR COVERAGE	<p><b>PROVIDE DETAILS ON YOUR PRIOR COVERAGE BELOW</b></p> <p>HAVE YOU AND/OR YOUR DEPENDENTS BEEN COVERED BY ANTHEM WITHIN THE PAST TWO (2) YEARS? <input type="radio"/> NO <input type="radio"/> YES - PROVIDE DETAILS BELOW</p> <p>HAVE YOU AND/OR YOUR DEPENDENTS BEEN COVERED BY ANOTHER CARRIER (BESIDES ANTHEM) WITHIN THE PAST TWO (2) YEARS? <input type="radio"/> NO <input type="radio"/> YES - PROVIDE DETAILS BELOW</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="font-size: 8px;">NAME OF CARRIER</th> <th style="font-size: 8px;">POLICY NUMBER</th> <th style="font-size: 8px;">DATES POLICY WAS IN EFFECT</th> <th style="font-size: 8px;">TYPE OF COVERAGE (SINGLE/FAMILY)</th> <th style="font-size: 8px;">REASON FOR TERMINATION (DIVORCE/DEATH)</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	NAME OF CARRIER	POLICY NUMBER	DATES POLICY WAS IN EFFECT	TYPE OF COVERAGE (SINGLE/FAMILY)	REASON FOR TERMINATION (DIVORCE/DEATH)										
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COMPLETE THIS SECTION IF YOU OR YOUR DEPENDENTS MAINTAIN OTHER EMPLOYER SPONSORED, INDIVIDUAL OR MEDICARE AS OTHER HEALTH COVERAGE						
ON THE DAY YOUR COVERAGE BEGINS, WILL ANY FAMILY MEMBERS YOU ARE ENROLLING BE COVERED UNDER ANY HEALTH COVERAGE? <input type="radio"/> NO <input type="radio"/> YES - IF SO, PROVIDE DETAILS BELOW						
OTHER COVERAGE	NAME OF PARTICIPANT	NAME OF CARRIER	PHONE # OF CARRIER	ADDRESS OF CARRIER (PARTICIPANT ID CARD)	POLICY NUMBER	EFFECTIVE DATE

COMPLETE INFORMATION BELOW FOR YOUR DISTRICT PAID, BASE LIFE INSURANCE BENEFIT					
LIFE INSURANCE INFO	PRIMARY BENEFICIARY NAME(S) - MUST ADD UP TO 100%	RELATIONSHIP	% BENEFIT	PHONE	ADDRESS

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by the Plan; (b) to be eligible for coverage, I must be an active eligible participant as defined by the policy(ies); (c) to be eligible for life and or disability income insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my life and/or disability coverage will begin on the day I return to work; (d) if coverage is issued, it will be based on full reliance on the information contained in this Application.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy or electronic reproduction of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that my dependents and myself are hereby eligible for coverage after review of the Plan's eligibility parameters. All information that I have provided is true and complete to the best of my knowledge.

Furthermore, I understand that if no coverage has been elected or I have selected a waiver, I hereby refuse the Plan offered by my employer and recognize that my future enrollment may be subject to certain restrictions as defined by the Plan. By enrolling, I authorize payroll deductions that are required for the benefits that I elect. I understand that my elections are irrevocable unless I have a Qualified Status Change. In addition, I understand that the benefits for which I have enrolled may not be immediately available or available to me based on eligibility exclusions, limitations or waiting periods and final coverage requires certification by human resources before is shall be activated.

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE