KIRKWOOD SCHOOL DISTRICT

EMPLOYEE HEALTH BENEFITS ENROLLMENT / CHANGE / CANCELLATION JANUARY 1, 2020 PLAN YEAR

Employer Use Only
Eff. Date : _____
Hire Date: _____
Approved by: _____

A. EMPLOYEE INFORMATION *(PLEASE PRINT)*

First Name	M.I.	Last Name	Social Security #	
Street Address		City	State	Zip
Phone # (include area code) ( )		Date of Birth	Sex	Marital Status: __ Single __ Married __ Widowed __ Separated

B. MEDICAL PLAN *(PRE-TAX)* UNITED HEALTHCARE

Kirkwood Self-Funded – Traditional Plan

Coverage Selection	Contribution / Month
__ Employee	$ .00
__ Spouse	$ 584.85
__ Child(ren)	$ 516.60
__ Family	$1,101.45

Kirkwood Self-Funded - HDHP/HSA

Coverage Selection	Contribution / Month
__ Employee	$ .00
__ Spouse	$ 405.00
__ Child(ren)	$ 344.00
__ Family	$ 749.00

__ Waive Coverage
I do not want medical insurance, but instead want to purchase a tax sheltered annuity from: _____

C. DENTAL PLAN *(PRE-TAX)* AETNA DENTAL PLAN

Coverage Selection	Contribution / Month
__ Employee	$ .00
__ Spouse	$ 36.69
__ Child(ren)	$ 54.00
__ Family	$ 68.18
__ Waive Coverage	

D. VISION PLAN *(PRE-TAX)* EYEMED VISION PLAN

Coverage Selection	Contribution / Month
__ Employee	$ .00
__ Spouse	$ 4.73
__ Child(ren)	$ 5.25
__ Family	$ 10.18
__ Waive Coverage	

E. ALL COVERED DEPENDENTS FOR MEDICAL, DENTAL, AND VISION COVERAGE *(PLEASE PRINT)*

Please list all eligible dependents you wish to cover under the medical, dental, and vision plans selected. Addition of individuals enrolled can only be allowed during Open Enrollment or if there is an eligible qualifying event.

Relationship	Last Name	First Name	MI	Social Security No.	Sex	Birth Date
Spouse						
Child						
Child						
Child						
Child						

F. OTHER HEALTH INSURANCE INFORMATION *(THIS SECTION MUST BE COMPLETED IF YOU HAVE OTHER INSURANCE AND DISTRICT INSURANCE*

Coverage: __ Medical __Dental	Insurance Company Name		Insurance Company Phone Number
Policy Coverage Dates _____ to _____	Name of Insured	Policy #	Family Members Covered
Insured's Employer		Insured Social Security #	

G. VOLUNTARY INSURANCE *(AFTER-TAX)* CIGNA

Voluntary LIFE INSURANCE
Coverage Selection

__ Employee
__ Waive Coverage

Voluntary LONG-TERM DISABILITY INSURANCE
Coverage Selection

__ Elect Coverage
__ Waive Coverage

Voluntary CRITICAL ILLNESS INSURANCE
Coverage Selection

__ Elect Coverage
__ Waive Coverage

Voluntary ACCIDENT INSURANCE
Coverage Selection

__ Elect Coverage
__ Waive Coverage

Voluntary HOSPITAL INSURANCE
Coverage Selection

__ Elect Coverage
__ Waive Coverage

I. VOLUNTARY INSURANCE *(AFTER-TAX)* UNUM

VOLUNTARY LONG TERM CARE INSURANCE
Coverage Selection

__ Employee Long Term Care
__ **Waive Coverage**

J. FLEXIBLE SPENDING ACCOUNTS *(PRE-TAX)* UHC

Annual enrollment form is required if FSA is elected. Once enrolled, you may not change your contribution until the next open enrollment, unless a qualifying change in family status occurs. If you are participating in the HDHP/HSA, you cannot elect Medical Reimbursement through Flex Spending.

__ Health Care Spending Account Contribution / Year $_____ ($1,000 min/$2,500 max)
__ Dependent Care Spending Account Contribution / Year $_____ ($1,000 min/$5,000 max)
__ **Waive Coverage**

K. EMPLOYEE AUTHORIZATION *(FORM MUST BE SIGNED)*

I have received and read the enrollment materials for Kirkwood School District's Employee Benefits Program and have made the above selections. I understand by signing this form, I am authorizing pre-tax contributions to be withheld from my paycheck for the health coverage and Flexible Spending Accounts selected. I further understand I cannot change my insurance elections or contributions to my Flexible Spending Accounts during the year unless I have a qualifying change in family status as described in the Flexible Spending Account enrollment guide. On behalf of myself and anyone enrolled on this application, I authorize any health care professional or entity to give insurance providers, the District, or any of their designees, any and all records pertaining to medical history or services rendered for any administrative purpose, including evaluation of an application or a claim. I also authorize the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made on this application may invalidate coverage. I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee, which can make me and/or my dependents subject to a pre-existing condition limitation. I further understand that if I decline enrollment for myself or my dependents because of other health coverage, I may be able to enroll in this plan in the future, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption.

X _____

Employee Signature Date Signed Building