SBCCOE

2022/2023 APT, Faculty & Staff Enrollment and Change Form

Medical ♦ Dental ♦ Vision ♦ Life

☐NBAJOBS	☐PDADEDN	☐Payroll
☐PDABENE	☐PDABCOV	☐_____
☐PDABDSU	☐PDAHIOC	☐_____

A. EMPLOYEE INFORMATION

Employee Last Name	Employee First Name	MI	Gender ☐M ☐F	Social Security Number - -

Home Address (address where you will receive member correspondence)	City	State	Zip Code

Home Phone Number	Institution Name	S#

Date of Hire	Effective Date or Date of Qualifying Event

B. CHANGES ONLY (Complete for changes to existing medical/dental coverage.)

☐**Addition** ☐**Deletion** ☐**Change**

Person(s)

☐Self
☐Spouse
☐Domestic/ Civil Partner
☐Child(ren)

Qualifying Life Event

☐Adoption ☐Lost Former Coverage ☐Death
☐Birth ☐Gained Other Coverage ☐**Open Enrollment**
☐Marriage ☐Dependent Child Ineligible
☐Divorce Dependent Name:_____

☐Other Event_____

Affected Plan/s

☐Medical
☐Dental
☐Vision
☐Life

For Name and Address changes, please contact your school's Human Resources office.

Comments:

C. COVERAGE DESIRED

Medical Plan Coverage		Dental Plan Coverage		Vision Plan Coverage (VSP)
☐Kaiser Permanente HMO	☐Employee Only	☐Delta Dental Option I	☐Employee Only	☐Employee Only
☐Anthem Blue Priority	☐Employee+Spouse	☐Delta Dental Option II	☐Employee+Family	☐Employee+One
☐Anthem Blue Advantage HMO	☐Employee+Children			☐Employee+Family
☐Anthem HDHP	☐Employee+Family			
☐Anthem Blue Preferred PPO	☐ No Change		☐ No Change	☐ No Change
	☐ Decline		☐ Decline	☐ Decline

D. LIST OF ELIGIBLE DEPENDENTS (List SELF and all eligible dependents you wish to cover.)

1.	SELF (Last, First, Middle Initial)	Social Security Number	Relationship	M/F	Date of Birth (MM/DD/YYYY)
			SELF		

OTHER INSURANCE ☐Yes ☐No COVERAGE SELECTED: ☐Medical ☐Dental ☐Vision ☐Life

2.	Name (Last, First, Middle Initial)	Social Security Number	Relationship	M/F	Date of Birth (MM/DD/YYYY)

OTHER INSURANCE ☐Yes ☐No COVERAGE SELECTED: ☐Medical ☐Dental ☐Vision ☐Life

3.	Name (Last, First, Middle Initial)	Social Security Number	Relationship	M/F	Date of Birth (MM/DD/YYYY)

OTHER INSURANCE ☐Yes ☐No COVERAGE SELECTED: ☐Medical ☐Dental ☐Vision ☐Life

4.	Name (Last, First, Middle Initial)	Social Security Number	Relationship	M/F	Date of Birth (MM/DD/YYYY)

OTHER INSURANCE ☐Yes ☐No COVERAGE SELECTED: ☐Medical ☐Dental ☐Vision ☐Life

E. LIFE INSURANCE

BASIC TERM LIFE

☐1 X Annual salary rounded up to nearest $1,000 (minimum $50,000)*
☐2 X Annual salary rounded up to nearest $1,000 (maximum $300,000)*
☐3 X Annual salary rounded up to nearest $1,000 (maximum $300,000)*
☐ Decline ☐ No Change

PRIMARY BENEFICIARY NAME (Last, First, Middle Initial)	**RELATIONSHIP**
CONTINGENT BENEFICIARY NAME (Last, First, Middle Initial)	**RELATIONSHIP**

DEPENDENT TERM LIFE ☐$5,000 ☐$10,000 ☐$20,000 ☐ Decline ☐ No Change

F. BEFORE OR AFTER TAX ELECTION

☐ I elect to reduce my gross wages and have all eligible medical, dental, term life and vision insurance premiums paid on my behalf with before tax dollars. Once elected, this before tax deduction(s) will continue each plan year until I sign a waiver. The waiver can only be signed during open enrollment or as the result of an eligible status or FMLA change. I understand that before tax premium payments cannot be applied toward a deduction on my federal tax return and that my PERA benefits may be affected by my before tax elections under this plan.

☐ I elect to pay my eligible premiums with after tax dollars.

I have read and understand the benefit choices available. I have read and understand the Kaiser Permanente Terms and Conditions as well as Anthem Blue Cross and Blue Shield provisions on the back side of this form. I also understand that my elections for insurance coverage will continue unchanged each plan year until I complete and sign a new Enrollment and Change form. Election changes are only allowed during open enrollment or as is consistent under the plan rules.

Signature	**Date**

*Benefits between ages 65-75 decrease, ask for the details

Anthem Blue Cross and Blue Shield and HMO Colorado Terms and Conditions

For more information about Anthem Blue Cross and Blue Shield, its products and services visit anthem.com.

The following applies to health plans coverage offered through Anthem Blue Cross and Blue Shield and HMO Colorado.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For individuals applying for BlueAdvantage HMO or Blue Priority HMO:

I understand that the services for which I and my dependents will be eligible, as described in the Certificate, must be obtained from the HMO Colorado Primary Care Provider I have selected.

Kaiser Permanente Terms and Conditions

I expressly authorize my doctor or hospital to furnish Kaiser Permanente any records concerning me or any other member of my family.

To the best of my knowledge, the information I have provided is complete and true and I understand that falsification by me will allow Kaiser Permanente to recover payments made, cancel membership and/or refuse to pay claims.

I hereby apply for enrollment for myself and my eligible family dependents listed. I understand that if Kaiser Permanente accepts this application, the benefits for which we will be eligible will be in accordance with the master contract applicable to the type of plan for which we are enrolled.

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.