SBCCOE

2018/19 APT & Faculty Employee Enrollment and Change Form

Medical ♦ Dental ♦ Vision ♦ Life

☐PDAHIOC	☐PDABDSU	☐VSP Website
☐NBAJOBS	☐PDADEDN	☐Payroll
☐PDABENE	☐PDABCOV	☐FAX FORM

A. EMPLOYEE INFORMATION

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

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

Institution Name	Medical Group Number (Required)	Dental Group Number (Required)

S#	Home Phone Number	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 ☐Anthem Blue Priority ☐Anthem HMO ☐Anthem HDHP ☐Anthem PPO	☐Employee Only ☐Employee+Spouse ☐Employee+Children ☐Employee+Family ☐ Decline	☐Delta Dental Option I ☐Delta Dental Option II	☐Employee Only ☐Employee+Family ☐ No Change ☐ Decline	☐Employee Only ☐Employee+One ☐Employee+Family ☐ No Change ☐ 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)	Primary Care Provider Name: MUST COMPLETE FOR BP & HMO COVERAGE	Current Patient
			SELF				☐Yes ☐No

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)	Primary Care Provider Name: MUST COMPLETE FOR BP & HMO COVERAGE	Current Patient
							☐Yes ☐No

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)	Primary Care Provider Name: MUST COMPLETE FOR BP & HMO COVERAGE	Current Patient
							☐Yes ☐No

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)	Primary Care Provider Name: MUST COMPLETE FOR BP & HMO COVERAGE	Current Patient
							☐Yes ☐No

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.

EMPLOYEE SIGNATURE (*Must have original signature*)	DATE

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

State Board for Community Colleges and Occupational Education (REV 04/18)

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 have indicated the Primary Care Provider of my choice, on the front of this application. 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

Conditions for Enrollment: I have read and agree to the terms and conditions of this enrollment form. Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians (“Respondent(s)”), which arise from any alleged failure or violation of, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

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.