Washington Court House School District

A. EMPLOYER INFORMATION:

Location	Hire Date	Date Waiting Period Began	Effective Date	Network	Basic Life/AD&D	Supp. Life	LTD
	/ /20	/ /20	/ /20		$ -	$ -	$ -

Application is for: ☐New Enrollment ☐ Enrollment Change (If change, check below)

☐Add Spouse ☐Add Child(ren) ☐Drop Spouse ☐Drop Child(ren) ☐Change Name ☐Change Address

B. EMPLOYEE INFORMATION:

Last Name	First Name / MI	Sex	Date of Birth	Social Security #	Phone #
		☐Male ☐Female	Mo/Day/Yr / /	- -	

Street Address	City	State	Zip Code	E-mail Address

C. DEPENDENT INFORMATION: (List all dependents to be covered under your chosen plan)

Last Name	First Name / MI	M/F	Date of Birth	Social Security #	Relationship	Add/Drop
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		

D. PLAN OPTIONS: (Please select your plan(s)

Medical Plan(s) Choose One	Enrollment	Dental Plan	Enrollment
☐PPO 500/1000	☐Enrollee Only	☐Elect	☐Enrollee Only
☐H S A	☐Enrollee + Spouse	☐Waive	☐Enrollee + Spouse
☐Bronze Plan	☐Enrollee + Child(ren)		☐Enrollee + Child(ren)
☐Waive	☐Family		☐Family

Supp. Life/Employee	Supp. Life/Spouse	Supp. Life/Child(ren)
☐Elect ☐Waive $	☐Elect ☐Waive $	☐Elect ☐Waive $

E. OTHER COVERAGE INFORMATION.

Does your spouse or any dependent have other health insurance? ☐Yes ☐No If yes, provide: Coverage Type ☐Medical ☐Dental ☐Vision

Name(s) of Covered Person(s) _____ Effective Date ___/___/___

Employer _____ (Name) (Address) (Phone#)

Claims Payor _____ (Name) (Address) (Phone#)

F. LIFE/AD&D BENEFICIARY INFORMATION:

Your Death Benefits are to be paid to First Beneficiary(ies):			If First Beneficiary(ies) is not living at your death, benefits are to be paid to Secondary Beneficiary(ies)		
Name	Relationship	% of Benefits	Name	Relationship	% of Benefits

ACCEPTANCE:

I hereby apply for group coverage for which I am or may become eligible as elected above. I authorize deductions, if any, from my compensation for my share of the cost of the coverages to which I become entitled. I understand that I must meet the eligibility requirements of the Plan and that the completion of this enrollment form does not guarantee coverage under the Plan. I affirm that the information contained herein is correct and true.

I elect to have my contribution to the cost of such coverage deducted from my pay on a pre-tax basis. I understand that the cost to me for coverage will be deducted from my gross earnings prior to calculation of certain taxes to be withheld each pay period. I also understand that I may not make any changes in my pre-tax election until the next pre-tax open enrollment period. However, I understand that an election change is permitted due to significant cost or coverage changes to me or a change in my family status as outlined in the Summary Plan Description.

Employee Signature _____ Date _____

DECLINATION:

I hereby decline medical coverage under my employer's medical plan for myself ☐ and/or my dependents ☐ I understand I may not be able to enroll until the next Open Enrollment Period or within 30 days of an event that qualifies as a "Special Enrollment" event.

Employee Signature _____ Date _____

PRE-TAX CONTRIBUTION DECLINATION:

Check and sign this box only if you want your contributions to be subject to payroll taxes

☐ I do not wish to have my share of the cost, for the coverages I have elected to be deducted from my pay on a pre-tax basis.

Employee Signature _____ Date _____

DELTA DENTAL®

Eligibility Enrollment/Update

Check: ❑ **Michigan** ❑ **Indiana** ❑ **Ohio**

Client Name: _____ Client#/Subclient# ____ – ____

Subscriber Information *(please complete for all enrollments/updates:)* Example: ABCDEF123456

Subscriber Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Subscriber Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____ Status* ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving Coverage Effective Date ___ – ___ – ____

Street Address ☐ Check here if this is a new address Email

City State ZIP Code ____ – ____

Plan Enrollment/Update Information *(please indicate type of update and fill in appropriate information):*

Type of Update: ☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination of Benefits

Group Transfer
From: Client/Subclient# ____ – ____ To: Client/Subclient# ____ – ____

Rate Code Change*
From: ___ To: ___

Effective Date of Change ___ – ___ – ____

Change is for: ☐ Subscriber ☐ Dependent

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

SPOUSE Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____ Status* ☐ Legal ☐ Surviving

DEPENDENT #1 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____ Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

DEPENDENT #2 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____ Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

DEPENDENT #3 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____ Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

DEPENDENT #4 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number ___ – ___ – ____ Birth Date ___ – ___ – ____ Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Subscriber's Signature _____ Date _____

314-55 (02-10)

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled “from” and the correct information should be listed on the line titled “to”.

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

Rate Codes:

- **Rate 1** Employee Only
- **Rate 2** Employee and spouse
- **Rate 3** Employee, spouse and children
- **Rate 5** Employee, one child, no spouse
- **Rate 6** Employee and more than one child, no spouse

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse

Surviving: The surviving spouse or child of a deceased subscriber.

IRS Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, **but only if specified in your group’s contract with Delta Dental.**

Delta Dental
Attention: Eligibility Processing
27500 Stansbury
Farmington Hills, MI 48334

WASHINGTON C.H. CITY SCHOOLS
306 HIGHLAND AVENUE
WASHINGTON C.H., OHIO 43160
Phone: 740-335-6620 Fax: 740-335-1245

DELTA DENTAL WAIVER FORM

Employee Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Employee Signature: _____

Date: _____

Note: This document waives all rights to dental coverage.

VSP
Vision care for life

Enrollment Form with Dependent Data

Name of group (employer): _____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected:

- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and family
- ☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP