Lincoln Benefit Trust
Self Funded Health Benefits

Enrollment Application & Change Form

(Please print or type)

FOR OFFICE USE ONLY

School District:

Effective Date: _____

TYPE OF ACTIVITY

❑ New Enrollment ❑ Enrollment Change ❑ Open Enrollment
❑ Add Dependent ❑ Address Change ❑ Name Change
❑ Other (explain) _____

GROUP INFORMATION

Highmark PPO Group #: _____

Highmark Classic Blue Group # _____

Delta Dental Group#_____

Davis Vision Group#_____

Sub-Group #: _____

I. GENERAL EMPLOYEE INFORMATION

Employee's Last Name	First Name		MI
Social Security #	**Date of Birth**		**Sex**
Home Phone # ( )	**Date of Hire**		**Marital Status**
Present Address	**City**	**State**	**Zip Code**

Plan: ☐ PPO with HRA
☐ QHDHP with HSA

If changing status or information, please indicate type of change (check all that apply)
❑ Name ❑ Address/Phone ❑ Add Dependent ❑ Other (describe)

II. ENROLLMENT / CHANGE INFORMATION

First Name & Middle Initial (show last name **only** if different from employee)	Social Security Number	Date of Birth	Sex	Elect (add) or Remove?	Disabled Dependent ?	Traditional	PPO	QHDHP	Dental	Vision	
Employee (Indicated Above) - - - - - - - - - - - - - - -	- - - - - - - - - - - - (Indicated Above)- - - - - - - - - - -			❑ Elect ❑ Remove							
Spouse				❑ Elect ❑ Remove							
❑ Son ❑ Dau				❑ Elect ❑ Remove							
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❑ Son ❑ Dau				❑ Elect ❑ Remove							
❑ Other Describe				❑ Elect ❑ Remove							

If a Dependent does not live with you or the last name differs from yours, please explain. _____

_____

_____

III. MEDICARE INFORMATION

Medicare Recipient	Health Insurance Claim #	Effective Dates		Disabled?	ESRD?
		Hospital (Part A)	Medical (Part B)		
				❑ Yes ❑ No	❑ Yes ❑ No

IV. OTHER INSURANCE INFORMATION

*Complete if **YOU** have any other health care coverage with another insurance company.*

Name of Employee	Name of Insurance Co.	ID / Policy #

V. DEPENDENT INFORMATION

Complete if DEPENDENT has other health care coverage with another insurance company

Name of Dependent	Relationship to Employee	Name of Insurance Co.

V. EMPLOYEE AUTHORIZATION

AUTHORIZATION: I certify that the information provided on this form is true to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Lincoln Benefit Trust and it's plan administrators may use and disclose Protected Health Information for payment, treatment and health care operations. I understand that this form enrolls those eligible persons listed above in the benefit plan described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

TO ELECT COVERAGE (must sign if coverage is elected)

1. I hereby apply for benefits provided by my Employer's Group Plan. I reserve the right to revoke this authorization at any time upon written notice.
2. I hereby certify that the Dependents listed are my dependents as defined in the Summary Plan Description. I agree to notify the Plan Administrator of any changes in status of any dependent or of any additional dependents I may acquire.
3. In the event my dependents or I suffer illness or injury because of an act or omission of a third party, I agree to so advise the Plan Administrator.
4. I hereby authorize my physician to release medical information to the health plan insurer or administrator

TO ACCEPT COVERAGE

I hereby authorize my employer to make salary reductions (if applicable) to be contributed by the School to the Plan for the cost of my health care benefits. I understand that unless I experience a family status change (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as determined by the Plan Administrator), the Annual Election Period is the only time I may change my benefit election.

Employee Signature _____ Date _____

TO DECLINE COVERAGE (must sign if coverage is declined)

TO DECLINE EMPLOYEE COVERAGE

I understand that I am eligible for benefits under the Group Health Plan. I certify that benefits under such Plan have been explained in detail. After careful consideration, I decline coverage under such Plan for myself.

Employee Signature _____ Date _____

TO DECLINE DEPENDENT COVERAGE

I understand that my dependents are eligible for benefits under the Group Health Plan. I certify that benefits under such Plan have been explained in detail. After careful consideration, I decline coverage under such Plan for my dependents.

Employee Signature _____ Date _____

VI. EMPLOYER AUTHORIZATION

Signature_____Title_____Date_____