



APPLICATION FOR ENROLLMENT/CHANGE OF STATUS

SUBSCRIBER INFORMATION - COMPLETE SECTIONS 1 THROUGH 4

New Enrollee Policy Change COBRA Enrollee

Social Security Number _____ Subscriber Last Name _____ Subscriber First Name _____ MI _____

Home Street Address _____ City _____ State _____ Area Code/Home Phone _____

Zip Code _____ County _____ Current Marital Status Single Married _____ Area Code/Work Phone _____

Job Title _____ Date of Hire or Full Time Status _____ Weekly Hours Worked _____ Annual Salary _____

List all persons to be enrolled/terminated:

Check One	NAME (List family members first name only, list last name if different than subscriber)	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	COVERAGES
<input type="checkbox"/> Add/Chg Term	Subscriber	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE MED <input type="checkbox"/> RX <input type="checkbox"/> DENT <input type="checkbox"/> VISION <input type="checkbox"/> SELF <input type="checkbox"/> 2 PARTY <input type="checkbox"/> FAMILY If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Spon. Dep. <input type="checkbox"/> Med. Supp. <input type="checkbox"/> If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____
<input type="checkbox"/> Add/Chg Term	Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____
<input type="checkbox"/> Add/Chg Term	Dep-1	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____
<input type="checkbox"/> Add/Chg Term	Dep-2	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____
<input type="checkbox"/> Add/Chg Term	Dep-3	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____
<input type="checkbox"/> Add/Chg Term	Dep-4	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____
<input type="checkbox"/> Add/Chg Term	Dep-5	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- - -	If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> Life <input type="checkbox"/> Basic Term Life \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> STD \$ _____ If over 19, is Dep. considered an IRS Dependent? <input type="checkbox"/> Full-Time Student? <input type="checkbox"/> LTD \$ _____

BENEFICIARY INFORMATION

I make the nomination of beneficiary with respect to all insurance provided now or at any time in the future under Policy above mentioned, hereby revoking prior nominations for such insurance, if any, and reserve to myself the privilege of making other and further changes subject to the policy provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein. If no designated beneficiary survives me, settlement will be made as provided in the policy(ies).

Be sure to list a beneficiary for the \$5,000 Life and AD&D insurance benefit included in the medical program, or Financial Security Plans.

Check one box only - please print My Estate Name _____

Mr./Mrs./Miss Last First Middle _____

Age _____ Relationship _____

Address (Number and Street) _____ State _____ Zip Code _____

Do you, your spouse or dependent(s) maintain other health coverage? No Yes **If Yes, complete below:**

NAME AND ADDRESS OF OTHER INSURANCE CARRIER	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
Are you, your spouse or any dependent(s) listed in Section 2 enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, complete below: (Attach a copy of Medicare Card(s).)		/ /	<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> ESRD (End Stage Renal Disease)	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Single <input type="checkbox"/> Family

Please check the appropriate box: Actively working Retired

I hereby apply to Benefit Plan Administrators (BPA) for the coverage indicated above. I authorize my employer/organization to deduct from my pay and remit any required contribution for the cost of said coverage. I authorize any medical professional, hospital, clinic or other medical or medically related facility, government agency, or other person to provide BPA information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness or use of drugs and alcohol. I understand that the kind of coverage for which I am making application contains coordination of benefits, workers' compensation, and subrogation provisions and acknowledge BPA's right to enforce these provisions. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by BPA. I understand I must notify BPA within 30 days of occurrence of any changes in status. I understand that if I am not actively at work on the date my coverage would otherwise become effective, my insurance will not begin until the day I return to work.

Applicants Signature: _____ Date: _____

EMPLOYER NAME: _____

Westwood Community School District

DATE OF EVENT: / /

CHANGES: Add Due to: Marriage Birth Adoption
 Drop Due to: Divorce Death Other
 Other Changes: Name Address Medicare Eligible Change of Coverage Other

NOTE: If your plan is subject to preexisting conditions and you have not been employed with your current employer for at least six (6) months prior to this Plan's effective date, you must provide a HIPAA Certificate of Creditable Coverage. Please refer to your "Initial Notice With Regards to Special Enrollment Rights and Preexisting Condition Exclusions." If you have not yet received this Notice, please see your employer for a copy of this Notice.