SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST

Benefits Enrollment / Change Form for PFSP Active Employees

For HR/Benefits use only
Coverage effective date _____
MONTH / DAY/ YEAR

Reason for Enrollment

❒ Open Enrollment ❒ New Hire ❒ Change in Status*

Date of Change _____ Reason _____

❒Enrolled in public healthcare exchange effective _____, 20____.

*Change in status is allowed for qualifying life events, which include but are not limited to:
- Marriage
- Divorce or legal separation
- Birth, adoption or legal guardianship
- Death
- Gain or loss of other coverage
- Full-time or part-time status change

You will be asked to provide documentation for these events. Find details at **http://sdtrust.com/benefits-whatif.html**.

Employee Information

(All fields are required)

LAST NAME	FIRST	INITIAL	EMPLOYEE ID NO.	WORK LOCATION

SOCIAL SECURITY NO.	DATE OF HIRE	EMPLOYMENT STATUS	DATE OF BIRTH
		❒ FULL-TIME ❒ PART-TIME	

HOME ADDRESS	CITY, STATE, ZIP	E-MAIL ADDRESS

HOME PHONE	WORK PHONE	MARITAL STATUS	GENDER
		❒ SINGLE ❒ MARRIED ❒ DIVORCED	❒ MALE ❒ FEMALE

Medical Plan

You must choose one.

Full-Time Employees	GROUP #	**Part-Time Employees — Option 1 & Option 2**	GROUP #
❒Providence Open Option	A008	❒ Providence Open Option — Option 1	A008
❒ Kaiser	1739-025	❒ Kaiser — Option 1	1739-025
❒ Providence Personal Option	A007	❒ Providence Personal Option — Option 1	A007
❒ Decline coverage		❒ Providence Open Option — Option 2	A012
		❒ Kaiser — Option 2	1739-026
		❒ Providence Personal Option — Option 2	A011
		❒ Decline coverage	

Dependent Information

If you are adding or dropping a dependent, complete the following section. To maintain your current dependents, check the box below.

❒ MAINTAIN CURRENT DEPENDENTS (If enrolling in a new medical plan, dependent's information must be provided)

Spouse/Domestic Partner

ACTION	LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NO. (REQUIRED)*	DATE OF BIRTH	GENDER	RELATIONSHIP
❒ ADD ❒ DROP						❒ MALE ❒ FEMALE	❒ SPOUSE ❒ DOMESTIC PARTNER

Children – If you need to enroll additional dependents please fill out and attach a second, signed enrollment form that lists them.

ACTION	LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NO. (REQUIRED)*	GENDER	BIRTHDATE MM/DD/YY	RELATIONSHIP: NATURAL/ ADOPTED/STEPCHILD	EMPLOYEE RESPONSIBLE FOR SUPPORT?	INCAPACITATED CHILD?
❒ ADD ❒ DROP					❒ MALE ❒ FEMALE			❒ YES ❒ NO	❒ YES ❒ NO
❒ ADD ❒ DROP					❒ MALE ❒ FEMALE			❒ YES ❒ NO	❒ YES ❒ NO
❒ ADD ❒ DROP					❒ MALE ❒ FEMALE			❒ YES ❒ NO	❒ YES ❒ NO

* Dependents will not be added if a social security number is not provided for that dependent.

You must inform the Trust if a dependent spouse, domestic partner or child is no longer eligible to receive benefits from the Trust. Please be aware if an individual who has been reported as your dependent receives benefits after Trust eligibility has ended, the Trust may recover the improperly-paid benefits from you.

Other Coverage

If you, your spouse/domestic partner or other dependents are covered by District coverage or by any other health care insurance, complete the following section:

Is your spouse/domestic partner also an employee of the School District?	❒ Yes ❒ No
Are you or any family member(s) covered by:	❒ Medicare ❒ Other coverage If yes, check the types of coverage ❒ Medical ❒ Dental ❒ Vision Complete the "Family Members Covered Under Other Coverage" section below.

Employee Information

LAST NAME	FIRST	INITIAL	EMPLOYEE ID NO.

Child Custody Information

If you or your spouse are divorced or legally separated, please indicate who has custody of your child(ren).	❒ Self ❒ Spouse ❒ Other
Has the parent without custody been mandated by court decree to provide coverage for the dependent child(ren)?	❒ Yes If yes, complete the "Family Members Covered Under Other Coverage" section below. ❒ No

Family Members Covered Under Other Coverage

To be completed only if you, or a dependent you are enrolling through the Trust, has other insurance.

NAME OF FAMILY MEMBER WITH OTHER COVERAGE	DATE OF BIRTH	NAME OF OTHER INSURANCE PLAN
NAME OF EMPLOYEE	GROUP ID NUMBER	EFFECTIVE DATE OF COVERAGE
CLAIMS ADDRESS		

Optional Term Life and Voluntary AD&D Insurance

GROUP NUMBER 750971

LIFE INSURANCE ❒ OPTIONAL (Additional) Term Life	REQUESTED AMOUNT $	*(Evidence of Insurability is required for amounts above $100,000.)*
DEPENDENTS TERM LIFE INSURANCE ❒ SPOUSE (Additional) Term Life	REQUESTED AMOUNT $	*(Evidence of Insurability is required for amounts above $30,000.)*
DEPENDENTS TERM LIFE INSURANCE ❒ CHILD(REN) Term Life	REQUESTED AMOUNT $	*(You may choose an increment of $2,000 to a maximum of $10,000.)*

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE
YOU MAY CHOOSE ONE OF THE FOLLOWING OPTIONS: ❒ You only (Up to $300,000) ❒ You and your dependents $

Beneficiary Designation for Basic Life/Optional Term Life and AD&D Insurance

Unless specified otherwise on a separate sheet of paper, this designation will also apply to Voluntary Accidental Death and Dismemberment (AD&D) insurance. Designations are not valid unless signed, dated and delivered to the Employer in your lifetime.

I elect: ❒ The Standard Order of Survivorship as stated in your group certificate — If you have a Domestic Partner, an Affidavit must be on file for distribution.

❒ To designate the following as beneficiary — Attach additional sheets if necessary.

Total of primary percentages must = 100% Total of contingent percentages must = 100%

NAME	ADDRESS	RELATIONSHIP	PRIMARY	CONTINGENT	WHOLE %
			☐	OR ☐	%
			☐	OR ☐	%
			☐	OR ☐	%
			☐	OR ☐	%

Signature

My signature below indicates that I have read and understand this enrollment form and descriptive materials provided. This enrollment form is binding on me and cannot be revoked or modified except as explained in the descriptive materials provided. I authorize my insurance carriers to obtain, examine, or release any medical or dental records or other information needed to coordinate benefits or process claims for me and my family members. I also authorize any provider having knowledge of my medical history or my dependents to release to my insurance carriers any medical information it requests. I authorize my insurance carriers to share such medical information with me or my dependents' health care providers. I declare that the dependents listed on this form are my eligible dependents. I also declare that the information furnished on this form is correct and complete to the best of my knowledge.

SIGNATURE VERIFYING I'VE READ AND UNDERSTAND MATERIAL _____ DATE _____

Declaration to Decline Coverage

I hereby decline coverage for Medical, Dental, Vision, Life Insurance, Accidental Death and Dismemberment, or Long-Term Disability coverage provided through School District No. 1 Health and Welfare Trust. I understand that I may not enroll for coverage until the next open enrollment period, unless I have a qualified change in status event. I understand that if I decide to enroll at a later date, I may be required to provide satisfactory Evidence of Insurability and the insurance carrier will have the right to refuse my request for insurance.

SIGNATURE TO DECLINE COVERAGE _____ DATE _____

Return completed form by mail, fax or email to:

Mail: PPS Benefits/BESC, 501 North Dixon Street, Portland, Oregon 97227-1804 | Fax: **503-916-3107** | Email: **benefits@pps.net**